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When the Bough Bends: Lived Experiences of Perinatal Anxiety

Thesis submitted by

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in September 2018

for the degree of Doctor of Philosophy

Society and Culture

College of Arts, Society and Education

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Declaration of ethics

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research. The proposed research study received human research ethics approval from the JCU Human Ethics Research Ethics Committee, Approval Number H6117.

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Abstract

In this thesis, I present qualitative critical feminist research that explores the lived experiences of women who identify as having perinatal anxiety. Perinatal anxiety is a highly prevalent mental health issue that has implications for women's morbidity and mortality, and for the physical, social, emotional and developmental wellbeing of their children. Dominant diagnostic custom has seen perinatal anxiety overshadowed by a focus on postnatal depression, resulting in a scarcity of research that considers perinatal anxiety as a standalone mental health issue. This research thus makes an important contribution to the academic discussion about perinatal mental health care.

The lived experiences of women with perinatal anxiety are largely absent in the literature; as a result, women continue to experience this debilitating condition in silence. I approached this critical feminist research using qualitative methods to collect and analyse the everyday narratives of women with perinatal anxiety to develop rich understanding of the experiences of perinatal anxiety and how they are influenced by dominant ideologies.

I carried out in-depth interviews with women who identified as experiencing perinatal anxiety, and with multidisciplinary perinatal practitioners. The interviews were conducted over a two-year period and were audio-taped and transcribed for a thematic analysis of the themes present in the data.

The narratives and perspectives of the women and practitioners led me to identify four overarching themes: 'Good Motherhood', 'Warning Signs and Cries for Help', 'Mental Health Literacy' and 'Strengths and Support'. These themes reflect the complex context of motherhood and mental illness and connect the everyday lives of women with

perinatal anxiety to a broader institution of oppression, silencing and control. The research sheds light on directions for future investigations and practice, including holistic and coordinated practice that considers the unique experiences of women with perinatal anxiety. This research recognises gaps in the mental health care approach for anxious mothers, including the mental health literacy of both practitioners and the women they treat. In this thesis, I make a call for social work to play a central role in providing care that recognises the multilayered biopsychosocial needs of women with perinatal anxiety, and that works to improve mental health literacy for consumers, practitioners and the broader community. Finally, I argue for the importance of a critical feminist approach to understanding the lived experiences of perinatal anxiety if meaningful change is to be achieved.

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List of Abbreviations

| | |
|-------|-------------------------------------------------|
| ABS | Australian Bureau of Statistics |
| ALSWH | Australian Longitudinal Study on Women's Health |
| EPDS | Edinburgh Postnatal Depression Screen |
| GAD-7 | Generalised Anxiety Disorder 7-item Scale |
| GP | General practitioner |
| NHMRC | National Health and Medical Research Council |
| PASS | Perinatal Anxiety Screening Scale |
| PMD | Postnatal mood disorder |
| PND | Postnatal depression |
| STAI | State-Trait Anxiety Inventory |
| WHO | World Health Organization |

Chapter 1: Introduction

The mental health of pregnant women and new mothers is a common public health issue in Australia. However, national statistics that relate specifically to the perinatal period (conception through to the end of the first postnatal year) are scarce (Lavender, Ebert, & Jones, 2016). Historically, the mental health of perinatal women was considered less important than their physical wellbeing, but recent evidence has found that the perinatal period is a time of increased risk for women to develop mental health issues (Austin, Middleton, & Highet, 2011; Lavender et al., 2016). The negative effects of poor mental health not only affect the pregnant or postnatal mother, but also her child and family. Perinatal mental illness is linked to poor emotional, social, physical and cognitive development in children, and can significantly influence parenting skills and secure parent/child attachment (Ayers, Coats, & Matthey, 2015; beyondblue, 2008).

There has been increased focus on perinatal mental health in Australia over the last decade, with the beyondblue's (2008) *The National Depression Program, 2001–2005* highlighting the prevalence of mental illness for perinatal women and the extent of maternal psychosocial morbidity. beyondblue's (2008) *Perinatal Mental Health National Action Plan* (2008) aims to address gaps in the care of perinatal women by encouraging improvement in specialised training, assessment and care pathways. Despite such initiatives, psychosocial mortality related to suicide, homicide and drug abuse has overtaken infection, abortion and pre-eclampsia as a leading cause of death for perinatal women (Humphrey, 2016). Perinatal specialist Humphrey (2016) notes that 'of the six most prominent causes of maternal death between 1973 and 2012, psychosocial death is the only group where the MMR (maternal mortality ratio) is rising' (p. 350). Despite this concerning trend, information is still lacking, and there

remains limited understanding of ‘late’ maternal deaths that occur after 42 days post-birth, although speculation suggests that suicide is a leading cause of death throughout the perinatal period. Maternal mental health statistics indicate that 15.2% of Australian women experience mental illness during childbearing; between 2008 and 2012, the deaths of 1 in 136 mothers were connected to poor mental health care during the perinatal period (Lavender, 2016).

The American Psychiatric Association (APA 2013, p. 222) defines anxiety as ‘an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure’. The term ‘perinatal anxiety’ refers to the anxiety women experience during pregnancy or in the year following childbirth (Dunn, 2016). Perinatal anxiety can occur alongside or independent from perinatal depression, but is often included under the broad label of postnatal depression (PND). Despite acknowledgement that ‘current evidence suggests that anxiety is at least, if not more common than symptoms of depression in the postnatal period’ (Seymour, Giallo, Cooklin, & Dunning, 2015, p. 314), perinatal anxiety has received less research and policy attention, and relatively little is known about it as a standalone mental health issue.

Motherhood is a key concern of feminist scholars and researchers, with many influential second-wave feminists such as Adrienne Rich (1976), Nancy Chodorow (1978), Sara Ruddick (1980) and Anne Oakley (1980) leading the critique of the mothering experience and exposing engrained social and political discourses that act to oppress mothers. Contemporary feminist scholars such as Andrea O’Reilly (2010) and Dawn Mannay (2015) continue to expand on and problematise motherhood, which is a contemporary concern in feminist discourse on the gendered oppression of women. As Mannay (2015) describes:

despite a pervasive rhetoric of agency and equality, the practice and performance of motherhood continues to operate within asymmetrical gendered and classed spaces inside the confines of respectable femininity ... women are led to believe that they can maintain the status of breadwinner, domestic goddess and primary care giver. (p. 1)

Despite motherhood being recognised as a contemporary source of women's oppression, scant research has been conducted in recent times that makes women's own narratives of motherhood visible. My research brings women's voices to the forefront of debate on mothering, mental illness and societal influence to strengthen knowledge about perinatal anxiety through the expert opinions of mothers themselves.

1.1 Topic Selection

In the pursuit of honest, ethical and above all else theoretically sound knowledge, it has been stated that one way to do this is by theorising or situating the subjective viewpoint of the researcher. (Harvey, 2013, p. 87)

Researcher identity plays an important role in social research. Rather than detaching identity from research, social researchers 'invest' themselves in their research, with the understanding that their identity shapes the research they perform (Harvey, 2013). My choice of perinatal anxiety as the focus of my research was influenced by my professional identity as a social worker. As an early-career social worker working in an acute care setting, I have found myself drawn to the health and wellbeing of women, particularly as they journey through motherhood. While providing therapeutic psychosocial care for women during their pregnancy, I recognised the significance of anxiety in the struggles of many women, and noted that anxiety appeared to be a misunderstood experience to which most practitioners were ill-equipped to respond. The women often presented as lost in an experience they did not understand,

and frequently resisted the label of PND, as they felt this did not reflect their experience. I began to question the adequacy of both the women's and their practitioners' knowledge of perinatal anxiety, and identified significant gaps in the timely and appropriate intervention for women. On further exploration, I found that the stories of anxious women I heard in my clinical role did not have a place in the academic literature or evidence-based practice that guides the practitioner response to perinatal mental health care. Marchesi and colleagues (2016, p. 543) also found this to be the case, stating that 'although [anxiety disorders] are diagnosed in 4–39% of pregnant women and in up to 16% of women after delivery, evidence on their clinical management is limited'. The literature and practice guidelines available to me focused strongly on depression and provided strategies and resources that were not necessarily appropriate for women who presented with anxiety independent from any depressive symptoms. Perinatal anxiety, it seemed, was an experience shrouded in silence, confusion and misdiagnosis. These clinical observations made me curious to know more about an experience that affects so many women, yet occupies such little space in the public discussion about perinatal mental health.

1.2 The Project: Aims, Design and Significance

This qualitative study explores the experiences of perinatal anxiety from the perspectives of mothers and practitioners. My aim for this research project was to better understand perinatal anxiety by addressing the following research questions:

- How do women describe their experience of perinatal anxiety?
- How is the experience of perinatal anxiety influenced by the broader social and political discourse of women's lives?
- What must be addressed to better support women who experience perinatal anxiety?

My research project is a qualitative study that explores perinatal anxiety through the lived experiences of women and the perspectives of perinatal practitioners. The project is underpinned by critical feminist theory, which views women's personal experiences as political and potentially challenging to the patriarchal oppression of women (hooks, 1989; Ramazanoglu, 1992). A critical feminist lens enabled my project to seek out and explore the lived experiences of a vulnerable and socially invisible group of women. With its emphasis on the power structures and complex interplay between the personal and political (Eagan, 2014), critical feminism shaped my approach to addressing my research aims and influenced my study design.

I recruited nine women and four practitioners from the South East Queensland region of Australia to participate in in-depth interviews about their experiences of perinatal anxiety. The audio-taped in-depth interviews were semi-structured and lasted for between 60 to 90 minutes. I carried out a thematic analysis of the interview data to establish key themes in the women's narratives that offer insight into the phenomenon of perinatal anxiety. This inductive method of analysis is flexible, and provided me with the tools to analyse women's experiences and develop rich, complex understanding of how their personal stories were connected to broad social theory and the gendered experience (Braun & Clarke, 2006). As Aronson (1994, p. 3) notes, 'when literature is interwoven with the findings, the story that the interviewer constructs is one of merit'. My data analysis identifies the complex interplay between motherhood discourse, women's gendered lives and mental illness.

This study is significant because it addresses gaps in knowledge about the experience of perinatal anxiety and brings the voices of marginalised women to the forefront of discussion. In this study, I aimed to 'do feminism' through research by producing knowledge that serves, and is generated by, women. I carried out this

knowledge building in anti-oppressive ways and theorised women's everyday lives through a critical feminist lens that questions issues of patriarchal power and control (Acker, Barry, & Esseveld, 1983).

My findings illuminate issues of importance for mothers with perinatal anxiety, and suggest ways forward for future clinical practice and research in this important area of women's health and wellbeing. The findings reveal areas of struggle for women who face a uniquely complex experience of oppression that is compounded by their gender, mothering role and mental illness. I make connections between women's everyday lives and the social forces that mould and constrict them, while also proposing the practical application of this knowledge for policymakers and practitioners.

1.3 Thesis Outline

Chapter 1 has introduced the study and argued for the significance of perinatal anxiety as a site of theoretical exploration.

Chapter 2 explores the key themes present in the literature on motherhood and mental illness. The literature review was conducted using a critical feminist lens, and it raises key issues in the historical and contemporary experience of womanhood, motherhood and mental illness. The literature reviewed presents what is known about perinatal anxiety today, and identifies the knowledge gaps this study aims to address.

Chapter 3 details the methodologies and research methods I used to design and carry out my research. I justify my choice of qualitative and critical feminist methodology and describe the methods used for recruiting participants and collecting and analysing the data. I also introduce the reader to my own narrative and the way in which my positioning as woman, mother and social worker influenced the research project. I then describe the challenges I faced during the project and the strategies I employed to undertake ethically sound research with a vulnerable group of participants.

Chapters 4–7 present the findings of my research. The findings section interweaves the data with my theoretical interpretations and links them to the relevant literature. Chapter 4, the first of the findings chapters, begins with an argument for the importance of hearing women’s voices in research and the politics of representation. I then introduce the reader to the participants to contextualise their narratives. The remainder of the chapter details the finding ‘Good Mothers’, where I argue that good motherhood discourses significantly shape women’s experiences of perinatal anxiety. In Chapter 5, I detail the finding ‘Warning Signs and Cries for Help’, where I identify the significant moments in the women’s narratives that initiated, exacerbated or redefined their experience of perinatal anxiety. I connect these key moments in the women’s lives to broader societal ideology and the gendered experience of motherhood. Chapter 6 details the finding ‘Mental Health Literacy’, where I describe the knowledge gaps of the women and the practitioners regarding perinatal anxiety. I argue that fragmented mental health literacy presented a barrier for the women to access timely and appropriate support and reinforced the silence shrouding their mental health experience. In Chapter 7, I detail the theme ‘Strengths and Support’, where I argue that stigma and fear present major barriers to women accessing support for perinatal anxiety. Key sources of support are identified, and social work’s potential role as central to recovery is noted.

In the final chapter, I present my concluding recommendations. Suggestions for future policy, practice and education are proposed based on my analysis of the narratives, and these suggestions are informed by the expert voices of the women themselves. I reiterate the importance of using a critical feminist approach to explore the phenomenon of perinatal anxiety, and contend that women with perinatal anxiety must be understood from a contextual perspective that recognises and challenges their oppression and the unique and complex experience of mental illness while mothering. I

argue that social work must take a central place in the care of women with perinatal anxiety, and make recommendations for social work-led research and practice in this specialised area. I also note the importance of increased education for perinatal women, practitioners and the broader community to nurture psychological literacy and counter stigma and misinformation.

Chapter 2: Literature Review

Our ideas about children and families are historically and culturally situated.

(Garey & Arendell, 2001, p. 293)

Critical feminism influenced all aspects of my research and informed my approach to this literature review. I sought out and reviewed literature that builds a contextual lens through which to view perinatal anxiety and speaks to the research questions. Rather than focusing solely on positivist sources of literature, I searched for those that could provide insight into the gendered experience of madness and motherhood. I also searched for stories from women themselves that hold an (albeit small) a place in the academic literature.

Guided by an inductive and responsive research approach, I engaged with the literature throughout the research project. I was often guided by the participants, who would spoke about concepts, experiences or forms of support that I would then explore through both scholarly and less formal ‘grey’ literature to contextualise this knowledge. Here, I have chosen to present the literature review in terms of themes that consider the historical and theoretical ‘bones’ of perinatal anxiety and the contemporary positioning of this phenomenon in Australia. I selected this method in recognition of the socially, historically and gender-bound nature of women’s experiences of maternal mental illness, since ‘mothering occurs within specific social contexts ... (and) ... is constructed through men’s and women’s actions within specific historical circumstances’ (Nakano, Chang, & Forcey, 2016, p. no page).

Qualitative research exploring perinatal anxiety is scarce, both in Australia and internationally. Despite recent quantitative studies that bring perinatal anxiety into focus, significant gaps remain in qualitative literature. These knowledge gaps particularly relate to the effect of anxiety on different demographic groups, the

effectiveness of detection and intervention and the experiences of women themselves (Austin et al., 2011).

I first explore the historical and contemporary understandings of mental illness in the context of womanhood and motherhood. I then examine past and present feminist thought on mental illness and consider the implications for current knowledge concerning perinatal anxiety. I conclude the chapter with key contemporary themes in the literature on perinatal anxiety. To build a broad and relevant picture of the perinatal anxiety experience in present-day Australia, I reviewed formal and informal sources of literature to uncover concepts that provide a foundation of thought for my study.

2.1 Women and Madness: Historical Themes

[M]ost women were not mad, merely seen as such ... what we call 'madness' can also be caused or exacerbated by injustice and cruelty, within the family and society. (Chesler, 1997, para. 14).

Women with mental illness endure a complex and layered experience of oppression. A full historical account of women's madness would not fit within the scope of this review, as women have been labelled as predisposed to madness since ancient times (Rawlings & Carter, 1977). Consistent with a critical feminist approach, I sought to build an understanding of women's mental illness that was firmly grounded in its historical context. I concentrate here on the significant historical shifts for women's mental health that occurred during the 1960s and 1970s. This period in history is of particular relevance to my research, as it was when the voices and subjective experiences of women were first recognised as valid and sought after in the realms of psychology and psychiatry (Mednick & Weissman, 1975). By exploring the historical understandings of mental illness and womanhood, I hoped to uncover the master

narratives (Taylor, 2010) that continue to inform knowledge about madness and womanhood in contemporary times.

The gendered experience of mental illness has long been of interest to feminists, but it was the second-wave feminism of the 1960s and early 1970s that heralded a notable shift in the ideology of women and madness. Qualitative researchers can approach a review of the literature by identifying sensitising concepts that qualitative writer Tracy (2012, p. 28) refers to as ‘jumping-off points or lenses for qualitative study ... (that) offer frameworks through which researchers see, organize, and experience the research problem’. I identified the following sensitising concepts in the literature about womanhood and mental illness: oppression, deviance, silencing and medicalisation.

2.1.1 Madness as oppression. Pieters (2017, p. 382) identifies the 1960s and 1970s as a time of ‘renaissance in psychotherapy’. New approaches in psychotherapy emerged during this period, such as Aaron Beck and Albert Ellis’ development of Cognitive Behavioural Therapy, which remains a cornerstone treatment approach of psychotherapy.

Women’s opportunities for engagement in social and political fields also underwent substantial shifts. Women, largely through their roles as nurses and social workers, began to influence the ‘man-made’ world of mental health care, resulting in changes to psychiatry and psychotherapy practices (Pieters, 2017). Including women in the field of psychology was significant, as much prior psychology research focused only on the behaviour and experiences of men (Denmark & Paludi, 2007).

During the early 1970s an anti-psychiatry movement took hold, hastening the demise of institutionalised psychiatry and heralding a shift towards community-based mental health care (Nolan & Hopper, 2000). This anti-psychiatry revolt prompted the

emergence of a biological model of madness and a surge in the prescription of psychotropic medication (Ussher, 2010).

Feminist counselling and psychotherapy emerged in the 1970s as a result of the strong feminist critique of a male-dominated mental health system. At this time, feminist critics unveiled traditional psychotherapy as a powerful tool of patriarchal society. Therapy served as a source of oppression, with women experiencing sexual exploitation, psychological abuse and excessive, involuntary treatment for mental illness (McLellan, 1995). The bias against women was proven in Broverman, Clarkson, Rosenkrantz and Vogel's (1970) study of the gendered opinions of psychotherapists. Broverman and colleagues (1970) found that psychotherapists rated a hypothetical healthy woman as more emotional, submissive and easily influenced and less competitive, adventurous and objective than a healthy hypothetical man.

Feminists began to argue that psychotherapy was an intervention designed and carried out by men that served to further devalue the personal emotional pain women experienced, and that supported a 'blame the victim' perspective. Marecek and Kravetz (1977) and others (Klein, 1976; Whitely, 1979) challenged the male-dominated field of psychology and argued that therapeutic practices strengthened men's power over women through hierarchical expert/patient roles and masculine psychological practices. Hurvitz (1973, p. 235) described psychotherapy as a tool for the oppression of women that 'protects the status quo against those who would change it; it psychologizes, personalizes and depoliticalizes social issues'. This act of depoliticalising, personalising and psychologising can be termed 'mystification' (McLellan, 1999). McLellan (1995, p. 146) defines mystification as 'the deliberate use of mystery, deceit, lies and half-truths for the purpose of presenting a false reality'. Feminists argue that traditional psychology, psychiatry and psychotherapy are agents of mystification that further

oppress women by reinforcing dominant ideology and promoting the expectation that women must change themselves to adapt to a false reality (Chesler, 1997).

Feminist understanding of mental health shifted significantly in response to these revelations, turning to a critique of madness as a method of controlling women. Feminists fought back by developing feminist psychotherapy, which provided an alternative to the psychotherapy offered by conservative mental health practice. It pushed for a new agenda that considered the influence of sex roles on psychology and the control and oppression that underpinned mainstream psychotherapy, and challenged the dominant ideologies of madness (Mednick & Weissman, 1975).

2.1.2 Silencing. The oppression of women's thoughts and feelings plays an integral role in the silence that surrounds mental illness and womanhood. By problematising woman's madness, early feminists argued that mental illness was as political as it was personal, challenging the dominant ideology that rendered women mad and sought to return such 'broken' women to their rightful place in society.

While immersing myself in the feminist literature on women's mental health, I realised that women have been silenced in two key areas: research and therapeutic intervention. Psychological research largely excluded women from the creation of new knowledge, leading to the view that men were the norm when addressing psychological distress (Denmark & Paludi, 2007). In the few studies of the 1960s and 1970s that explored sex and gender differences between men's and women's psychology, results portrayed women as inferior to men by their very nature (Denmark & Paludi, 2007). Early psychology's refusal to acknowledge the complete human experience of mental illness undoubtedly acted to silence and further oppress women, resulting in what Denmark and Paludi (2007, p. 6) refer to as the 'science of white male behaviour'.

Intersectionality – a framework of analysis that considers the ‘interaction of multiple identities and experiences of exclusion and subordination’ – was used by feminists to problematise women’s experiences of mental illness (Davis, 2008, no page).

The absence of women’s experiences in psychological research understandably influences diagnosis, treatment and recovery. Theorists such as Parsons (1960) argued that labelling women as mentally ill served to silence them and ensure men’s control and power. This silencing of women’s experiences effectively excluded those experiences from the public and political arena, supporting a view of women’s lives as contained within the home. Like oppression, silencing is not only of historical significance to the lives of women; contemporary theorists maintain that the separation between public and private continues to influence women’s lives (Baumeister, 2009; Fraser, 1989). Because of the silencing of women’s subjective experiences, psychotherapy has largely been delivered from what Stoppard (1997, p. 11) terms the ‘women’s body approach’. Stoppard describes this approach as focused exclusively on women’s bodies as the source of psychological disorders, and links it to dominant biochemical explanatory models that occupy much of the space in psychotherapy. A woman’s body approach acts to exclude social factors and gendered sources of distress from consideration when diagnosing and treating women’s mental illness (Neitzke, 2016; Stoppard, 1997).

Psychotherapy treatment has contributed to the silencing of women throughout history. Traditional psychotherapy views madness as a problem within the individual, rather than a problem within the broader socio-political context. McLellan (1999, p. 325) argues that tradition psychotherapy has ‘let women down’ because of a failure to acknowledge the oppression and injustice that frames the women’s experiences.

Feminists such as Ussher (1991) have argued that madness portrays the power of the medical man over the deviant woman, with treatments such as the ‘rest cure’ serving to repress women. The ‘rest cure’ was predominantly used in the treatment of hysteria, and involved the patient being isolated, put on bed rest and prevented from engaging in any mental activities. This oppressive treatment method was used on many women who were considered outspoken and argumentative, and Ussher connects this to a direct form of social control and silencing of women who would otherwise challenge gender norms.

2.1.3 Madness as deviance.

[F]or women both close conformity to and departure from their roles are liable to generate definitions of psychiatric problems. (Wright & Owen, 2001, p. 147)

Feminists throughout history have raised concerns about the way women’s madness is intrinsically linked to perceived notions of deviance from the societal script. Murray and Finn (2011, p. 52) argue that ‘blame for a woman’s (madness) is not far removed from medicalized notions of the faulty, excessive and uncontrolled female body that can readily fall prey to it’. Understanding madness as a deviant behaviour first requires a normative standard to which women are held. In her work *True Womanhood*, Welter (1966) described this standard of womanhood as one where women judged themselves, and were judged by others, in terms of their affinity with the core cardinal virtues of ‘true’ womanhood: piety, submissiveness, purity and domesticity. Women were understood to value love over justice, which positioned them as a potential source of deviance and disorder to social and political order (Pateman, 1980). Theorists such as Freud (1922) and Rousseau (1910/2009) argued that women were innate nurturers and lovers who did not possess the ability to develop or maintain a commitment to justice.

Betty Friedan is another key contributor to the understanding of women’s normative roles during this time. Friedan’s (1963) seminal work *The Feminine Mystique*

shone light on the ‘problem that has no name’. Friedan argued that women were living an empty and lonely existence, troubled by their own disillusionment with their roles as mothers, wives and homemakers; Friedan termed this vague dissatisfaction and longingness for more as the ‘problem’ that women could not name. She expanded on the concept of mystification, arguing that women had been caught up in a false truth that promised happiness and fulfilment by embracing femininity and the role of wife, mother and housekeeper. Friedan remains a feminist icon for her role in demystifying the false reality of the ‘happy housewife’, and challenging the satisfaction women were expected to derive from existing solely in the private sphere of society. Friedan’s thinking came at a time where women were encouraged to embrace their post-war existence and aim for the desired life of a suburban housewife (Sanders, 2007). This dominant message led women to strive for lives situated in a false reality. Friedan exposed the mystification of the happy housewife by problematising womanhood and femininity and revealing the reality of women who did not find complete fulfilment in their roles as wives and mothers.

As Welter’s and Friedan’s arguments show, the dominant discourse of womanhood worked to shape the ideal female role and, subsequently, women’s behaviour. Chesler (1997, p. 56) notes that ‘women who fully act out of the conditioned female role are clinically viewed as neurotic or psychotic’. Thus, women who rejected or were ambivalent towards their conditioned female role were considered threats to the political and social order, both by themselves and society (Chesler, 1997; Pateman, 1980). The concept of deviance suggests that woman’s mental health can be wielded as a powerful tool of social regulation.

2.1.4 Medicalising women’s unhappiness. Why and how women experience mental illness is another key focus of feminist literature. Historically, madness has been

intrinsically linked to women's bodies through menarche, menstruation, pregnancy and menopause; however, feminist scholars have questioned the biological cause of madness and argued that women's discontent was medicalised. The argument behind the medicalisation of women's unhappiness considers women's discontent with their gendered existence as the underlying reason for the label of madness. Feminists such as Wright and Owen (2001) suggest that psychology and psychiatry not only oppress women through treatment, but oppress all women by instilling them a fear of the label of madness should they venture outside their proscribed female role.

In the 1970s, hysteria became a widespread diagnosis, particularly in the treatment of middle-class women. Hysteria was considered a woman's illness, and linked to female biology (Jimenez, 1997). Feminists drew connections between the changing gender norms of the 1960s and the sudden psychiatric preoccupation with hysteria. The symptoms of hysteria were so vast and varied that almost all women's behavioural characteristics were considered reason enough to suggest a diagnosis of the disorder (Jimenez, 1997). Thus, women with undesirable personality characteristics, those who questioned their female role and those who supported the feminist cause were all considered potential 'sufferers' of hysteria and labelled mad (Jimenez, 1997).

2.2 Women and Madness: Contemporary Themes

In my review of key contemporary literature on women's mental health, I identified key concepts that illuminate the issue of perinatal anxiety. Here, I review contemporary literature that covers the themes of 'Women's Mental Health' and 'Women and Anxiety'.

2.2.1 Women's mental health. Women's mental health is a key focus globally, with the World Health Organization (WHO) exploring the gendered nature of mental illness. The WHO's (2000; 2013) contemporary research and recommendations arising show a

significant change to the way women's madness is perceived today compared with historically. The WHO recognises the role of gender in determining women's mental health and wellbeing, and the broader social context that influences women's experiences. In a stark shift away from historical perspectives of women and madness, the WHO (2013, p. 8) states that 'recent research suggests that the impact of biological and reproductive factors on women's mental health is strongly mediated and, in many cases disappears, when psychosocial factors are taken into account'. This recognition that women's bodies are not to blame for experiences of mental illness indicates the positive steps being taken towards understanding women's mental health.

In another notable turn from the historical discussion, research by and about women has gained momentum. An example of this new focus on researching women's mental health needs is the Australian Longitudinal Study on Women's Health (ALSWH), which recently published an annual report on the health of Australian women (Chojenta, Lucke, Forder, & Loxton, 2016). The ALSWH is Australia's largest and longest running study on the health of women. It reached 58,000 participants in 2016, and assesses women's physical and mental health, socio-demographic and lifestyle factors, and use of health services (ALSWH). The report outlines a 2016 study by Chojenta et al. (2016) in which a range of risk factors for PND are identified based on the ALSWH's longitudinal data. The study found that over 15% of Australian women had experienced PND, with the strongest positive associations being for postnatal anxiety, followed by antenatal depression. Risk factors for developing perinatal mental illness included a history of depressive illness, emotional distress during childbirth and short duration of breastfeeding (Chojenta et al., 2016). Chojenta and colleagues concluded that women's history of mental health was important in

identifying those vulnerable to PND and suggested that treating mental illness earlier in women's lives may reduce the incidence and severity of PND.

Despite this encouraging interest in women's health research, women with mental illness continue to face greater disadvantage than men. As the WHO (2013) contends, women still experience specific and disproportionate risk factors for mental illness, including gender-based violence, low income, socio-economic disadvantage, subordinate social status and care responsibility for others. Women are statistically more likely to attract a mental health diagnosis, even when their clinical presentation and assessment scores are the same as men (WHO, 2013). Women have a higher prevalence of depression and anxiety in their lifetime compared with men, and are more likely to experience clusters of mental health disorders (WHO, 2013). Women are predominately affected by disorders such as generalised anxiety, depression, agoraphobia, panic disorder, somatisation and hypochondriasis (WHO, 2013). This gender bias is also evident in the disproportionate prescribing of psychotropic drugs for women, a continuing trend that speaks to the historical theme of medicalising women's unhappiness.

The WHO (2013, p. 10) recommendations show a clear swing away from the individualised and siloed approaches of the past, with suggested interventions now considering a life-course approach that recognises the full range of women's 'psychosocial and mental health needs ... by acknowledging current and past gender specific exposures to stressors and risks ... life circumstances ... and ongoing gender based roles and responsibilities'.

Psychology scholars Williams and Watson (2016) argue that women with mental health issues must be reframed from being 'mentally ill' to 'survivors of their lives' to conceptualise their complex gendered experience of mental health. Williams

and Watson also identify interpersonal violence and abuse as an experience embedded in gender inequality and posit that women's contemporary mental health experience is firmly situated within gendered power relations that see women and girls as disproportionately affected by violence, sexual assault and physical, psychological, sexual and financial abuse. This childhood and adulthood abuse places women and girls at significantly greater risk of psychological difficulties, and leads Williams and Watson (2016, p. 1) to assert that 'there is a wealth of evidence that alerts us to the risks embedded in women's lives that originate in systems of inequality'.

Poverty and socio-economic disadvantage is also recognised as a direct influence on mental health (Williams & Watson, 2016). Women living in poverty experience stigma, humiliation, desperation, dehumanisation and shame that negatively influence their psychological health. Women also continue to have less access to important resources such as safety, status, money and power.

Carter (2014) argues that gender socialisation and the teaching of 'expected' gendered roles keeps contributing to women's mental health. Women are socialised to meet dominant expectations, such as being dependent, emotionally expressive, cooperative, multitasking, attractive and nice and becoming nurturing and attentive mothers (Carter, 2014; Williams & Watson, 2016). However, men are still being socialised in the ways of control and power. They are encouraged to meet the expectations of masculinity, which includes the traits of individualism, competitiveness, bravery and domination.

Understanding the ways in which women's distress is identified and responded to is linked to the previously discussed theme of medicalising women's unhappiness. Psychiatric diagnosis, labelling, medicalised responses and individualised treatment continue to plague women and sever connections to the social and gendered context

within which women's unhappiness exists. The literature suggests the need for gender-informed care that realises 'the importance of the social context, particularly the social inequalities impacting on women's lives' and can assist women with working towards recovery by navigating and surviving their lives in transformative ways (Against Violence and Abuse & AGENDA Alliance for Women and Girls at Risk, 2017, p. 1).

2.2.2 Women and anxiety. Anxiety is the most prevalent mental health disorder in Australia. On average, one in three women will experience anxiety at some stage in their life (Australian Bureau of Statistics [ABS], 2008). Aboriginal and Torres Strait Islander women are nearly three times more likely to experience significant psychological distress than non-indigenous Australian women (ABS, 2013).

During the last decade, Australian research has broadened to include analysis of mental illness in the context of women's gendered experiences. Examples include research on perinatal mental health, gender-based violence (Rees, Silove, Chey et al., 2011), poverty (Kiely, Leach, Olesen, & Butterworth, 2015), cultural background (Lee, Harrison, Mills, & Conigrave, 2014) and care responsibilities (Williams & Cowling, 2008).

2.3 Motherhood and Madness: Historical Themes

[W]e cannot understand individuals without measuring their perceptions of and experiences with the dominant cultural and historical discourses about motherhood. (Henderson, Harmon, & Newman, 2016, p. 516)

Feminist psychotherapist McLellan (1995, p. 7) speaks of the societal expectations placed on women, and these are captured poignantly in her assertion that, in a patriarchal society, 'the important requirement is that [women] give the illusion of happiness so that life can run smoothly for everyone around them ... whether they are, in fact, happy or not is of no consequence'.

Motherhood has been at the forefront of feminist debate for many decades. Of particular significance, the early 1980s saw feminist scholars question the foundations of motherhood and the influence of patriarchy on the mothering experience (Umansky, 1996). From my review of the literature I identified the following key themes; ‘Good Mothers’, ‘Mothering from the Margins’ and the ‘Disillusionment with Motherhood’.

2.3.1 Good mothers.

[T]he good mother is known as that formidable social construct placing pressure on women to conform to particular standards and ideals, against which they are judged and judge themselves. (Goodwin & Huppatz, 2010, p. 2)

The concept of ‘good mothers’ holds an important space in both historical and contemporary feminist literature in relation to the ideology of motherhood. Feminists have been concerned with dominant ideologies of motherhood for many decades, and the societal designation of mothers as good or bad continues to suppress and control the experience of motherhood for women. Feminists argue that motherhood, like womanhood, is shaped and controlled by a gendered system that defines women by their adherence to standards and expectations of mothering. This idea of motherhood as an institutionalised experience is informed by the theoretical work of earlier feminist scholars, namely Adrienne Rich (1976), Nancy Chodorow (1978) and Sara Ruddick (1980).

2.3.2 Motherhood as an institution.

I try to distinguish between two meanings of motherhood, one superimposed on the other: the potential relationship of any woman to her powers of reproduction and to children; and the institution, which aims to ensure that that potential—and all women—remain under male control. (Adrienne Rich, 1976, p. 1)

In her seminal work *Of Woman Born*, Adrienne Rich (1976) engaged in a critical examination of the social construction of motherhood. Rich's arguments in *Of Woman Born* were the first of their kind to put forward such feminist considerations of motherhood. Rich unravelled the complex overlap between motherhood as a source of oppression and motherhood as a source of creativity and pleasure. It was this critique that propelled the analysis of motherhood into a space that acknowledged the contrast between societal expectation, control and oppression and the experience of motherhood as emancipatory and powerful. As feminist scholar O'Brien Hallstein (2010, p. 25) describes,

Rich challenged deeply held beliefs that motherhood and mothering were biological imperatives and, as such, she was the first feminist to explore and articulate an early social constructionist view of motherhood. Her claim that motherhood was fundamentally a social condition rather than a biological imperative deeply confronted the then—prevailing understandings of and roles for women.

Rich's work has paved the way for feminist scholars to keep problematising motherhood and exploring the complexity of women's lives.

Feminist psychologist and sociologist Nancy Chodorow's 1978 book *The Reproduction of Mothering* is another key theoretical work that approached motherhood from a psychoanalytic perspective that aimed to shift focus to the interconnectedness of women's psyche, society and culture. *The Reproduction of Motherhood* emphasised the importance of women's subjective experience, women's psychology and the mother–daughter relationship. Chodorow (1978, p. 34) drew attention to the social construction of motherhood and gender norms, arguing that 'women's mothering as an organisation of parenting is embedded in and fundamental to the social organisation of gender'. Like

other feminist scholars of the time, Chodorow problematised women's role as mothers and helped highlight the role of political, social and economic institutions in constructing and maintaining dominant mothering ideology (Guerrina, 2010).

Chodorow (1978, pp. 75–76), like Rich, argued that motherhood served the interests of society, stating 'there does not seem to be evidence that exclusive mothering is necessarily better for infants. However, such mothering is "good for society" it has facilitated several other tendencies in the modern family such as nuclearization and isolation of the household, and the belief that the polity, or the society, has no responsibility for young children'.

However, Chodorow's work has not gone uncriticised. Some have argued that Chodorow placed too much emphasis on the individualised experience and the assumption of a generic family form, and does not address the diversity of women's experiences in terms of race, sexuality or spirituality (Heenan, 2002).

Radical feminist philosopher Sara Ruddick is another influential scholar who contributed to feminist analysis of motherhood. Ruddick's views contrast with those of Rich and Chodorow in that she takes a 'pro-family' feminist stance by supporting mothering as a powerful social practice. In her work *Maternal Thinking*, Ruddick (1980) argued that mothers maintain a contradictory role cloaked in power and powerlessness. She called for mothers to refashion their domestic lives and for the personal be considered political, and argued that men needed to be involved in all aspects of maternal care to promote egalitarian gender roles, warning, 'men's domination is present when their absence from the nursery is combined with their domination of every other room' (Ruddick, 1980, p. 360).

Ruddick's views contradict those of other feminists who argue that scholars such as Ruddick reinforce the divide between public and private realms, which goes against the feminist cause (Dietz, 1985)

Rich, Chodorow and Ruddick generated important discussion about the hidden lives of mothers and drew attention to the socially constructed and oppressive institution of motherhood. Their views are still relevant today, with feminist maternal scholars arguing that the institution of motherhood must remain a core concern of feminist debate (Warner, 2005).

2.4 Motherhood and Madness: Contemporary Themes

I now discuss the contemporary landscape of motherhood, with key themes including 'Modern-day good mothers', 'The Motherhood Myth' and 'Mothering from the Margins'.

2.4.1 Modern-day 'good' mothers. There is literature confirming that the contemporary presence of the 'good mother' ideology continues to affect the experience of women. Despite decades of feminist critique and rejection of motherhood as good, perfect and natural, the ideal of the 'good mother' remains predominant and continues to influence the women who aspire to or outwardly reject it (Murray & Finn, 2011). A discussion of contemporary good motherhood is important here, as good mother discourses work to shape how women feel—for as Johnstone & Swanson (in Goodwin & Huppertz, 2010, p. 6) state, 'A good mother is a happy mother; an unhappy mother is a failed mother'.

Berggren-Clive's (1998) feminist, qualitative study found that women fear being labelled 'bad' mothers and further believe that perinatal mental illness is an indicator of bad mothering. Mothers experiencing mental illness have been found to fear failure and assume they will be considered 'bad' mothers should they admit to an experience of

mental illness (Edwards & Timmons, 2009; Nahas, Hillege, & Amasheh, 1999). I argue that this fear is due to the dominant mothering discourse that demands ‘good’ mothers be void of negative emotions. As Murray and Finn (2011, p. 50) describe, ‘frustration, anger, bad feelings and guilt is seen as something that goes against the established norms of good mothering and that interferes with a preferred kind of maternal identity and self-knowing’. This fear of ‘bad’ mothering can be linked to a woman’s experience of stigma when living with perinatal mental illness. Rubin (1967) suggests that the good mother ideology is an external discourse women internalise to create an ideal image of themselves as mothers. This image reflects each woman’s perception of what constitutes ideal maternal behaviour, and is often unattainable. Thus, women find themselves consumed by negative emotions for not meeting the unattainable ‘good mother’ status that society would have them believe others hold.

2.4.2 The motherhood myth. The ‘good mother’ ideology creates and sustains a motherhood myth. Like Rich (1986), Westall and Liamputtong (2011) argue that the dominant discourse of motherhood is shaped by social arrangements and norms that operate on a political level that goes beyond the personal choices or paradigms of individual mothers. These ideals form what Henderson et al. (2016) term the ‘motherhood myth’: a dominant public discourse that depicts a fantasy of the perfect mother. The motherhood myth is intrinsically linked to the myths of womanhood. As radical feminist McLellan (1999, p. 333) states, ‘today’s suggestion that “women can do anything” focuses attention on individual women. It deceives women into believing that whether or not they can “do anything” is entirely a matter of individual effort’.

McLellan’s point can be used to facilitate our understanding of motherhood and the myths of the ‘good mother’. If women are led to believe that they should be perfect

mothers if only they try hard enough, then the motherhood myth continues to be strengthened.

Maushart (1997) speaks of the 'mask of motherhood' as the façade that mothers observe, absorb and aspire to. Maushart (1997, p. 21) describes the mask of motherhood as 'an assemblage of fronts, mostly brave, serene and all-knowing, that we use to disguise the chaos and complexity of our lived experience'. This mask protects the 'good mother' ideology from the critical gaze and questioning of women who do not relate to this unachievable ideal. When mothers do not identify with such expectations, they can experience conflict that Berggren-Clive (1998, p. 111) terms 'the disillusionment with motherhood'. This crisis of disillusionment and feelings of an ill fit with mothering can significantly affect self-esteem and women's experiences of motherhood (Oakley, 1980). Thus, the power of the motherhood myth, just like that of the feminine mystique, places pressure on women to meet unattainable ideals that result in eroded self-esteem and increased stress and anxiety (Weshall & Liamputtong, 2011).

The myth of motherhood is termed the 'new momism' by Douglas and Michaels (2004, p. 4), who characterise the dominant motherhood discourse as an unachievable fantasy that insists:

that no woman is truly complete or fulfilled unless she has kids, that women remain the best primary caretakers of children, and that to be a remotely decent mother, a woman has to devote her entire physical, psychological, emotional, and intellectual being, 24/7, to her children. The new momism is a highly romanticized and yet demanding view of motherhood in which the standards for success are impossible to meet.

Goodwin and Huppatz (2010, p.3) also contribute to the field, suggesting that mothering ideals and expectations are 'produced and reproduced in a variety of ways:

through media mis/representations, through government policy, via the organisation of institutions such as work and education, and as the result of deeply held cultural beliefs'. Reese, Gandy and Grant (2003) also argue that mothers reflect upon their sense of self and success as mothers using certain social contexts that are strongly dominated by media.

2.4.2.1 Social media and the motherhood myth. During the interview stage of my research, I noted that the women spoke of social media and online content as a key source of motherhood guidance and influence. The internet is considered women's main source of parenting guidance (Rothbaum, Martland, & Jannsen, 2008), and women's membership of virtual communities has been linked to increases in support and changes to dominant mothering ideology (Madge & O'Connor, 2006). The anonymity offered when participating in the virtual realm is considered a source of empowerment for women, and has encouraged their engagement in the public sphere of discussion, debate and knowledge creation (Madge & O'Connor, 2006). The rise of women's access and involvement in the virtual realm reveals a trend of openness and honesty about experiences and thoughts that are typically considered 'private'. This openness is suggested to occur more with complete strangers online than in face-to-face communication (Wellman & Gulia, 1999), which raises interesting questions about the empowering nature of online realms for mothers whose experiences may be silenced elsewhere.

In response to participants' voices and the inductive style of my research, I broadened the review to explore the literature surrounding social media and the influence positive and negative sources might have on mothers.

2.4.2.1.1 Mummy bloggers. In a growing trend, blogs (informal, conversational-style webpages produced by individuals or small groups) have become a popular avenue for

the public communication of personal experiences and perspectives (Rogers, 2015). Of interest to my research are the rising numbers of mothers who have taken to blogging to express their raw and uncensored lived experiences. ‘Mummy bloggers’, as they are commonly called, appear divided between those who reinforce dominant motherhood ideology, and those who loudly and actively challenge it.

Feminists have acknowledged mummy blogging as a potential radical act that can work to challenge and change the dominant ideologies of motherhood (Lopez, 2009). Blogging is thought of as a radical act because women use it to enter and influence the public sphere. Public and private dichotomy is a key factor in the mummy blogger phenomenon. Mummy bloggers have faced controversy and criticism, even from within the field of women bloggers (Lopez, 2009). This is potentially linked to the dominant view of motherhood as, even more so than womanhood, confined to the private, domestic sphere. Through their narratives, mummy bloggers essentially situate their private lives firmly within the male-dominated public sphere, unveiling their experiences for all to see. Mummy bloggers hold particular power because they facilitate the production of knowledge, resulting in a ‘grass roots’ emergence of truth and guidance. This knowledge creation is found in the development of community discourse where women themselves determine knowledge, rather than seek institutionally generated knowledge in a top-down approach to knowledge building (Blair & Takayoshi, 1999).

Despite the argument that mummy blogging is a radical act that can challenge the oppression of women (Lopez, 2009), I noted a divide between those who reinforce dominant motherhood ideology and those who challenge it.

Controversial mummy blogger Constance Hall is an Australian mother of four who shot to fame when her brutally honest portrayal of motherhood saw her attract

upwards of one million online ‘followers’. Hall’s fame and popularity appear linked to her willingness to share raw and uncensored truths about her experience of womanhood, motherhood, marriage, body image, sexuality and mental illness. Hall created the #likeaqueen campaign, where she uploaded an unedited photo of herself in her underwear (see Figure 1.1) and called for fellow ‘Queens’ to share their own photos of their ‘royal bodies’ (Hall, 2016). Her book, *Like a Queen*, has sold over 150,000 copies and boldly discusses issues such as motherhood, anxiety, PND, sex, competitive birthing, body image, infidelity, guilt, parenting and abortion.



Figure 2.1: Constance Hall (Hall, 2016)

I interpret Hall’s blogs as a challenge to dominant ideologies of motherhood in much the same way that Adrienne Rich detailed her personal experiences of raising her children to push through her critique of broader societal discourse (O’Brien Hallstein, 2010). Like the feminist foremothers of maternal critique, Hall asks the unaskable questions and seeks to challenge the dominant narrative of motherhood with comments such as, ‘you feel like you have to be eternally grateful for having kids’, and ‘we can hate our jobs so why can’t we hate parenting?’ Comments from Hall’s followers show the powerful influence of her honesty on breaking down the mothering myth for women. Comments from readers, which include, ‘I love your honesty. Made me consider that perhaps I’m not doing it all so badly after all’, and ‘your honesty is so raw and made me tear up as this is everyone’s life experience if only they were real’, reveal

the strong influence one mother can have on others when she dispels the motherhood myth. Hall's brutally honest portrayal of motherhood can be viewed as a radical act in that it achieves what virtual realms are best at: it allows women to 'temporarily transcend local moralities of mothering' (Madge & O'Connor, 2006, p. 210).

Although Constance Hall's mummy blogging contribution can certainly be perceived as radical and consciousness-raising in nature, not all mummy bloggers aim to dispel the motherhood myth. Madge and O'Conner (2006) identify a clear paradox in the realm of online interaction, where liberation and oppression compete for influence.

In a striking comparison to Hall, mummy blogger Jessica Shyba's (see Figure 2) blog *Momma's Gone City* is awash with images of her smiling children, and while she does admit that 'I don't have a perfect formula for making sure each child's love tank is filled, and I certainly don't know how to do all of this and make sure my husband gets what he needs, too' (Shyba, 2017), most of her writing celebrates the ease, joy and natural nature of mothering. Shyba's blog can be seen to meet and reinforce the expectations of the motherhood myth: a happily married career woman with five pleasant and photogenic children who seems to have motherhood completely under her control.



Figure 2.2: Jessica Shyba (Shyba, 2018)

Mummy bloggers arguably hold a position of power in relation to other women, for ‘mothers are influenced by media messages about good and bad celebrity moms, which forces them to put on a mask of “the doting, self-sacrificing mother and wear it at all times”’ (Douglas & Michaels, 2004, p. 6).

2.4.3 Mothering from the Margins

Raith, Jones and Porter (2015, p. xii) describe mothers in the margins as those who ‘feel alienated or stigmatised, mothers who have been rendered invisible, mothers who feel they have been silenced. Mothers who, through a perception that they do not fit the accepted and expected norms of motherhood, have been relegated to the margins!’ Women who experience mental illness prior to, or during, motherhood are particularly at risk of being relegated to the margins. Madness is a concept portrayed as incompatible with ‘good’ and ‘normal’ motherhood, a dominant societal paradigm that fuels alienation, stigmatisation and shame for women whose situation deviates from the ‘norm’. The feminist critique of motherhood challenges the view that ‘women, womanhood and women’s bodies represent private; they represent all that is excluded from the public sphere’ (Pateman, 1989, p. 4). The suppression of the motherhood experience as ‘private’ works to further relegate mothers to the margins, effectively silencing and siloing the experiences, knowledge, realities and difficulties of motherhood from the public sphere and, indeed, from other mothers. As depicted in *The Feminine Mystique*, mothering from the margins effectively isolates women from one another and from the patriarchal society that actively suppresses them.

In their qualitative study, Westall and Liamputtong (2011) explored the adjustment to motherhood of 33 women, and yielded interesting findings. Women who participated in their study perceived themselves as mothering alone, regardless of their marital status and available support network. Westall and Liamputtong found that

women felt unprepared for motherhood and struggled to adjust to mothering roles, which they perceived as in conflict with their expectations of motherhood. When seeking support, women turned to their own mothers, even when those relationships were tense, distant or non-existent. Overwhelmingly, women felt that they did not receive the emotional and practical support and guidance they needed from their own mothers, and sought motherhood guidance from books and online sources in a trial-and-error approach to learning how to mother. Westall and Liamputtong concluded that women were often isolated from other mothers, a result of the cultural shift from ‘it takes a village to raise a child’ to one of women mothering alone. These findings reflect those of other academics (Buultjens & Liamputtong, 2007; Mauthner, 2002; Morrow, Smith, Lai, & Jaswal, 2008) who have identified the lack of support women receive from their own mothers and the isolated reality of motherhood.

2.5 Perinatal Anxiety: Contemporary Themes

Here, I move away from my focus on the construction of motherhood and outline key concepts present in the literature concerning perinatal anxiety. Perinatal anxiety disorders affect about 24.1% of pregnant women, with studies suggesting that more new and expecting mothers will experience an anxiety disorder than a depressive disorder (Matthey, Barnett, Howie, & Kavanagh, 2003). Perinatal anxiety can be debilitating and detrimentally affect both mother and child—for the child, it can lead to poor attachment, adjustment and coping difficulties, low infant birth weight, premature birth and longer term cognitive and behavioural issues (Hoang, 2014; Huizink et al., 2014; O’Connor, Heron, & Glover, 2002; Simpson, Glazer, Michalski, Steiner, & Frey, 2014; Weisberg & Paquette, 2002).

Perinatal anxiety poses a great risk to the wellbeing, morbidity and mortality of mothers and infants, but has long been considered a comorbidity of depression rather

than a serious mental health issue in its own right (Simpson et al., 2014). The most routinely used perinatal distress screening tool, the Edinburgh Postnatal Depression Screen (EPDS), reflects this view of anxiety as secondary to depression. The EPDS is a self-rated, non-diagnostic screening tool designed to identify depression markers and risk factors requiring further intervention (beyondblue, 2011). Although the EPDS has evolved to include a subscale for the screening of anxiety symptoms, questions remain about its validity and effectiveness as a screening tool for perinatal anxiety (Matthey et al., 2003; Simpson et al., 2014).

In their Canadian study Simpson et al. (2014) explored the Generalised Anxiety Disorder 7-item Scale (GAD-7), a screening tool developed to identify generalised anxiety disorder to determine its effectiveness for use with pregnant and postnatal women. Two hundred and forty women with a clinical diagnosis of anxiety were selected as participants and completed both the GAD-7 and EPDS. Simpson et al. (2014) compared the screening results with the participants' clinical diagnoses to evaluate the psychometric properties of the GAD-7 and EPDS in a perinatal context. The findings suggest that the GAD-7 is clinically useful for identifying generalised anxiety disorder in a perinatal context, displaying greater specificity and accuracy for generalised anxiety disorder and comorbid anxiety and major depressive disorder (Simpson et al., 2014).

An Australian study carried out by Laios, Head and Judd (2013) also questioned the validity of routine screening practices in the perinatal period. The authors argue that existing screening tools have become standard practice despite poor evidence of their influence on maternal morbidity. Laois et al. raise issues regarding the effectiveness of 'one size fits all' screening tools and contend that a solid evidence base does not underpin the screening of women during the perinatal period. They call instead for the

focus of perinatal mental health to be on physician education and training, individualised assessments that take demographics and social context into consideration and an understanding of perinatal mental illness as '*not just depression*' (Laois et al., p. 172).

A qualitative Canadian study by Wardrop and Popadiuk (2013) explored the transition to motherhood and experiences of anxiety through narrative research. Wardrop and Popadiuk (2013) identified five main themes from their in-depth interviews with mothers: experiences of anxiety, expectations of a new mother, issues of support, societal scripts of motherhood and transition to motherhood. They emphasise the importance of a holistic understanding of anxiety for mothers and propose that the definition of postpartum distress be expanded. The study recommends improvements in healthcare practice to better recognise, validate and support postnatal women experiencing anxiety (Wardrop & Popadiuk, 2013).

In their quantitative research report, Matthey et al. (2003) argue for anxiety disorders to be recognised as a significant risk factor for perinatal mood disorder and advocate for improved screening, assessment and treatment for new mothers and fathers. Despite a limited explanation of the study's underlying methodology, Matthey et al. provide evidence of systematic and rigorous methods for data collection and identified important gaps in existing research and practice. The study draws attention to the mental health of new fathers: it explored couple concordance when PND screening was broadened to include anxiety disorders. The authors' conclusions call for the term PND to be replaced with postnatal mood disorder (PMD) to more accurately acknowledge and respond to mental health issues for new parents. The need to assess for anxiety and depression is considered key to providing appropriate mental health care in the perinatal period (Matthey et al., 2003).

In their study, McDonald et al. (2012) also focused on screening tools for identifying perinatal distress. A preventative framework was used to design an antenatal screening tool that was then compared against the EPDS in terms of its ability to predict anxiety symptomology in postnatal women. McDonald et al. assessed variables including socio-economic status, relationships, support and history of abuse or depression. They used the EPDS, Cohen Perceived Stress Scale and State-Trait Anxiety Inventory (STAI) in their assessment of screening tools for postnatal distress to develop an integer score-based prediction rule, which demonstrated that antenatal psychosocial issues showed causal links to postnatal psychological distress.

A study by Somerville et al. (2014) presented a preliminary validation of the Perinatal Anxiety Screening Scale (PASS) developed to screen for anxiety symptoms sensitive specifically to perinatal women. Somerville et al. screened participants with the PASS, EPDS, Depression Anxiety and Stress Scale 21, STAI and the Beck Depression Inventory II, and included in their analysis the participants' social circumstances and demographics. Findings suggest that the PASS tool identified anxiety disorders more effectively than the EPDS and recognised risk of perinatal anxiety in the context of: acute anxiety and adjustment; general worry and specific fears; perfectionism, control and trauma; and social anxiety (Somerville et al., 2014). Study findings conclude that current screening practice with the EPDS may fail to identify women who are at risk of, or experiencing, significant anxiety (Somerville et al., 2014).

2.5.1 Perinatal anxiety: misunderstood, minimised and overlooked. In my review of contemporary literature for perinatal anxiety, I identified a key concept of perinatal anxiety as misunderstood, minimised and overlooked. I noted a theme across both quantitative and qualitative studies suggesting that perinatal anxiety is an overlooked and minimised risk factor for women.

Studies (Matthey et al., 2003; Somerville et al., 2014; Wardrop & Popadiuk, 2013) have argued that anxiety is a mental illness that dominant societal paradigms have deemed less important than depression, a contention supported by historical and contemporary values of diagnosis, intervention and risk. The contemporary literature on the topic suggests a need to encourage dialogue on screening, assessing and valuing perinatal anxiety in its own right to overcome the mindset that ‘even when anxiety symptoms are a prominent feature, hierarchical diagnostic custom requires that depression as a label, takes precedence’ (Matthey et al., 2003, p. 144). This diagnostic custom is arguably linked to the current knowledge of perinatal anxiety, with qualitative research on the topic scarce, and the experiences of women with perinatal anxiety largely absent in the literature (Lavender & Jones, 2016).

Wardrop and Popadiuk’s (2013) qualitative study considered perinatal anxiety a standalone issue. Their in-depth study gathered findings from interviews with six women who had postnatal anxiety and calls for increased understanding and improved responses to anxiety disorders:

One woman explained that when she went to see her doctor because her emotions were very different from anything she had experienced before, she reported that ‘he kind of heard my stories and said “well you’re not depressed, so you’ll figure it out. It’ll sort itself out in a couple of days, or a couple of weeks, or however long it’s going to take”’. (p. 12)

The narrow focus of perinatal mental health screening continues to be a significant issue for social research, practitioners and women experiencing a perinatal mental illness other than depression (Matthey et al., 2003; Somerville et al., 2014). The literature indicates concerns about the distress and associated risk that can be overlooked when screening women for perinatal mental health issues. It is suggested in the literature that this is due to the narrow definition of perinatal distress that groups all mental health issues under the umbrella of PND (Wardrop & Popadiuk, 2013). The story told by a participant in Wardrop and Popadiuk's (2013, p. 10) study reveals the consequences of such narrow definitions: she shared the confusion she felt when her experience of anxiety did not 'fit' within the only postnatal mental illness she knew of: 'I felt like this must be postpartum depression, right, because that's the only sort of term I could come up with that was something - "postpartum something"'.

Matthey and colleagues (2003) expand this exploration by asking the question 'What happened to anxiety?'; arguing that anxiety disorders are not recognised through screening unless they are experienced alongside a depressive disorder. This minimisation of anxiety disorders has been attributed to 'hierarchical diagnostic custom', whereby depression is deemed to deserve and receive greater medical attention (Matthey et al., 2003, p. 144). This statement not only resonates with the experiences of women in Wardrop and Popadiuk's (2013) study, but also with the scope and focus of other two studies that have sought to screen and predict anxiety separately from depression to gain true understanding of what is experienced under the broad definition of PND (McDonald et al., 2012; Somerville et al., 2014).

2.5.2 Insufficient screening. My review of the literature found controversy regarding the screening tools for perinatal mental health. Insufficient and inappropriate screening, which fails to identify anxiety in pregnant and postnatal women, resulted in research

that critiqued the EPDS, querying its ability to accurately identify women experiencing perinatal anxiety. A common thread of doubt surrounding the EPDS's ability to screen for anxiety is prevalent, with researchers (Matthey et al., 2003; McDonald et al., 2012) questioning the validity of screening for anxiety with a tool designed to identify risk of depression.

Scope of screening is also considered a concern, with suggestions that current screening practices are too narrow to appropriately identify perinatal mental health issues. Lack of specificity is another barrier to appropriate screening, with anxiety measured through the use of general screening tools or depression screens potentially limiting the effectiveness of those tools (Somerville et al., 2014; Wardrop & Popadiuk, 2013). Specificity and scope have been identified as issues in perinatal anxiety screening, with findings showing that women with anxiety scored significantly lower on the EPDS than those with depression; this means that a large number of distressed mothers are potentially excluded from receiving further support or intervention (Matthey et al., 2003).

Content of current screening measures is a third key concern for the effective screening of perinatal anxiety (Matthey et al., 2003; Somerville et al., 2014). Concerns are present in the literature about whether the screening questions in the EPDS are able to distinguish between anxiety symptoms that are a factor of a depressive illness, or an anxiety disorder as a separate clinical presentation. The questions in screening tools such as the EPDS pose limitations to appropriate perinatal anxiety screening, with many psychologically distressed women remaining undiagnosed or misdiagnosed because they do not meet the criteria for depression (Matthey et al.; Wardrop & Popadiuk, 2013). Findings from Wardrop and Popadiuk's (2013, p. 18) study show that women's

experiences of screening reflected concerns about the content of screening methods, and emphasise:

a need to specifically recognize and name the varying experiences of postpartum distress [as] participants mentioned that they had been assessed for postpartum depression, but did not meet the cut-off score on the EPDS for depression and were, therefore, not identified as needing help.

2.5.3 Early intervention. Early intervention and prediction is considered vital for effectively identifying and managing perinatal anxiety. Causal links have been made between antenatal anxiety and postnatal anxiety (McDonald et al., 2012), with researchers calling for antenatal screening that can determine risk within a preventative and early intervention framework (Somerville et al., 2014). Wardrop and Popadiuk (2013) assert the need for changes in screening and treatment for women who experience perinatal distress and highlight the opinions of their participants, who described being ‘lost’ in the screening process and subsequently excluded from support and treatment. Matthey and colleagues (2003, p. 142) also contribute to this argument with their findings that ‘assessing for the presence of anxiety disorders greatly increases the rate of women and men having distress to the level of caseness [for] affective disorder’.

2.6 Social Work and Perinatal Anxiety

Australian social work shares a lengthy history with mental health work, dating back to the 1940s (Martin, 2013). The role and scope of social workers in mental health has helped change the landscape of psychological care, shifting focus from a biological model of mental illness to a biopsychosocial approach (Engel, 1977). Australia’s mental health service structure has altered significantly over time, with care moving from institution to community, promotion of early intervention and coordinated care and

efforts to improve the care available for consumers (Council of Australian Governments, 2006). These policy changes have created the opportunity for social work to play a more central role in the care of people with mental illness.

Anxiety disorders are core business for social workers in mental health, with a 2010 survey study finding that depression (93%) and anxiety (90%) are the most prevalent disorders seen in private sector practice (Martin, 2013). Perinatal mental health is also recognised as a component of Access to Allied Psychological Services, a 2001 Australian Government initiative that enables doctors to refer patients with mental health issues to social workers and other allied health professionals (Australian Association of Social Workers, 2017). Despite anxiety occupying an important space in the duties of social workers, the role of social work in perinatal anxiety is difficult to discern because of a lack of literature. This absence of social work in the academic discussion of perinatal anxiety is concerning, particularly when one considers the influence of psychosocial factors on women's experiences of mental illness. Mental health social work scholars have contended that social workers hold a unique skillset that positions them to 'understand the broader political and socioeconomic context of the lived experience of consumers and carers and are skilled at strategies that engender hope' (Martin, 2013, p. 281).

Social work is underpinned by critical theory that 'places significant emphasis on reflecting upon how dominant ideologies or ways of thinking, as well as societal institutions, impact on people's lives' (Allen, Pease & Briskman, 2003, p.2). Feminist social workers practice from a position that considers a woman's personal problems to be political and focus their efforts on 'the manner in which social problems are defined, the development of feminist campaigns and networks, social work in statutory settings, counselling and therapy, and feminist working relations' (Martin, 2003, p.28). Social

workers are arguably well suited to the holistic and socially aware support of vulnerable women, and yet evidence of this work is difficult to find.

2.7 Where to from Here: Holism, Breadth and Distinction

A final theme that I identified in the contemporary literature is the future direction of perinatal anxiety management. I found considerable emphasis on the need for broader and more holistic definitions, understandings and screening criteria for perinatal mental illness. Researchers (Matthey et al., 2003; Wardrop & Popadiuk, 2013) have called for changes to the conceptualisation of perinatal mental illness to reflect the broader spectrum of issues women face, and have suggested that making a distinction between anxiety and depression is vital to providing appropriate perinatal mental health care (Somerville et al., 2014).

Studies have also highlighted the importance of recognising perinatal distress for fathers, calling for further research to explore couple concordance, which could better address the needs of mothers and fathers during the perinatal period (Matthey et al., 2003). However, this view contrasted with that of some participants in Wardrop and Popadiuk's (2013, p. 15) study, who stated: 'The [educational resources] for dads ... actually talk more about psychological issues than the women's ones do ... whereas the books mothers read are like technical parenting baby-care books'.

The effect of psychosocial factors is a growing focus in the literature (Somerville et al., 2014; Wardrop & Popadiuk, 2013), and recognises the influence of class, socio-economic positioning, gender, culture and societal norms on women's experiences of anxiety, as described by participants in Wardrop and Popadiuk's (2013) study:

So, there's lifelong expectations ... I mean you're kind of bombarded by it. And so all of those expectations, when they're not being lived out, which were my experience, then that directly affects the anxiety level (p. 14).

[I had to] negotiate between Canadian cultural values and [East Asian] cultural values. Language is one item that parents have to, that I have to decide. Not knowing what resources are available, not having a support group, dealing with cultural differences. (p. 16)

Matthey et al. (2003) advocate for the traditional PND focus to be broadened to acknowledge anxiety disorders. The term PMD (postnatal mood disorder) has been suggested as a replacement for PND (postnatal depression) in an effort to encourage a more holistic approach to perinatal distress and allow appropriate recognition of, and distinction between, mental health issues (Matthey et al., 2003). Women who had experienced perinatal anxiety gave a subjective argument for the need to have better terminology and distinctions, as noted by Wardrop and Popadiuk (2013, p. 18):

They spoke strongly of feeling misunderstood and alienated amidst the dominant discourse that implies that postpartum depression is a single, distinct issue, and perhaps, the only issue that really counts. Women who did not show symptoms of, or resonate with, descriptions of depression, often felt marginalized by friends, families, and professionals.

2.8 Conclusion

My review of key literature explores what historical and contemporary academia says about women's experiences of perinatal anxiety, the influence of broader social and political discourse, and what must be addressed to better support women who experience perinatal anxiety. In this chapter, I have argued that women's experience of perinatal anxiety is influenced by historical concepts of womanhood, motherhood and

madness. The 1960s and 1970s were critical periods in the theorising of motherhood, and continue to influence the present-day institution of motherhood. The work of early maternal feminists has offered a vital critique of motherhood as a complex and layered experience of oppression. My review of the literature provides insight into the oppression experienced by ‘mad’ women and argues that mental illness can be used as a tool of patriarchal control. Motherhood further complicates this experience of oppression, and radical and critical feminist thought has problematised motherhood and challenge its institution.

Contemporary literature that addresses how women describe their experience of perinatal anxiety is lacking, particularly qualitative work that brings the lived experiences of women to the academic conversation on perinatal mental illness. The existing literature addresses ways in which support can be improved for women who experience perinatal anxiety. The literature suggests issues with effective screening tools, terminology and dominant diagnostic custom as barriers to recognising perinatal anxiety as a standalone mental health issue. Screening is evidenced across the literature as insufficient and inadequate, and could be considered negligent. Holistic and broad approaches to screening that recognise the distinctiveness of perinatal anxiety as a disorder are recommended. My review of the literature also raises need for change and highlights issues of distinction, breadth and holism for future screening practice and research, which would view perinatal anxiety as a contextual, significant and complex experience.

The literature speaks to a need for a holistic approach to perinatal anxiety, and I have identified the lack of a social work presence in the field of perinatal mental health care. I argue that this absence of social work in perinatal mental health literature is concerning, as perinatal mental health and anxiety disorders represent core business for

mental health social workers. Given the complex interplay of psychosocial factors in the experience of perinatal anxiety, social work appears well suited to occupying a key role in knowledge creation and in providing care for women with perinatal anxiety.

In Chapter 3, I outline the methodological underpinnings of my research study and the methods that I used to explore the experiences of perinatal anxiety and introduce the reader to the participants of my research study.

Chapter 3: Methodology and Methods

In this chapter, I discuss the methodological frameworks that have informed each stage of my research. I describe the influence of qualitative and critical feminist methodologies on how I approached, shaped and presented my research. I then introduce the reader to my own biographical narrative and speak to the importance of critical reflexivity in terms of both qualitative and critical feminist research. In the second half of the chapter, I turn to the methods I used to recruit participants, collect data and then analyse and present the findings. I address the ethical and moral challenges of the study before closing the chapter by introducing the reader to the participants of my research study.

3.1 Methodology: Critical Feminist and Qualitative Approaches

Once settled on the topic of perinatal anxiety, I concentrated on choosing a methodology that would best guide the research process.

- How do women describe their experience of perinatal anxiety?
- How is the experience of perinatal anxiety influenced by the broader social and political discourse of women's lives?
- What must be addressed to better support women who experience perinatal anxiety?

Clarke and Braun (2017, p. 297) define methodology as 'a theoretically informed, and confined, framework for research'. When crafting the methodological approach for the study, I took many factors into account. First, I had a commitment to hearing and valuing women that was driven by my connection to feminism, critical social work values and mental health theory. I wanted to use a methodological approach that would value and enhance the theoretical base informing the research, and in doing so, uncover how women describe their perinatal anxiety, how their experiences are influenced on a societal and political level and what needs to be addressed for future research and practice. Second, I needed a research methodology that could produce a depth and richness in the data that would be able to respond to the research question

about ‘experiences’ and ‘perspectives’. ‘Experiences’ and ‘perspectives’ are subjective terms, and I needed a methodological approach that would complement this subjective focus. Third, the literature revealed gaps in the existing knowledge base evidenced by an absence of qualitative research addressing perinatal wellbeing. I recognised the overwhelming dominance of positivist quantitative methodology that shaped the way in which perinatal mental health was portrayed, understood and responded to, and wanted to address this knowledge gap through my choice of methodology. The clear absence of women’s lived experience of anxiety in the literature was critical in influencing my choice of a qualitative and critical feminist methodology.

3.1.1 Qualitative methodology. Qualitative methodology challenges the traditional research values of objectivity and generalisability and is judged more on its ability to discover rich, vivid and accurate knowledge about complex phenomena (Rubin & Rubin, 2012). Qualitative research is about ‘understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences’ (Merriam, 2009, p. 6). Qualitative methodology was a comfortable fit for my study, as it provided me with an approach that could potentially reach across the researcher and participant divide, forming connections, building understanding and facilitating learning about the experiences of women who were both similar and strikingly different from me. Had I wanted to establish the prevalence of perinatal anxiety or the effectiveness of a particular treatment project, I may have considered a quantitative or mixed method design. However, what I set out to discover was how women with perinatal anxiety interpreted and understood that experience. Rather than seeking one ‘truth’, I wanted to develop an understanding of what perinatal anxiety meant for women and consider this from a critical perspective within the context of a patriarchal society. Qualitative research uses an emic approach, whereby theory

emerges from the research process, rather than an etic approach, where external theories are applied to determine meaning (Tracy, 2012). This inductive research methodology appealed to my critical feminist positioning, as I could seek knowledge from the material lives of women—this approach values women’s expert voices and lived experiences. I chose a qualitative methodology because it can yield rich data ‘that are detailed and varied enough that they provide a full and revealing picture of what is going on’ (Maxwell, 2013, p. 126).

Qualitative methodology supports the feminist perspective that reality is socially constructed, research is often value-laden, and relationships between participants and the researcher are essential (Denzin & Lincoln, 2011). I do not believe that I could have achieved the data I desired through quantitative methodology, as its focus on generalisability, control and measurement would have devalued women’s personal accounts of their lived experience and the meaning they attribute to the phenomenon of perinatal anxiety.

3.1.2 Feminist research: Talking back to sociology.

The point is not only to know about women, but to provide a fuller and more accurate account of society by including them. (DeVault, 1999, p. 30)

Feminist theory has informed all parts of this research project, from conception to completion. Critical feminism has been particularly influential in my methodological approach, through which I sought knowledge from women to explore their unique experiences of motherhood and shed light on these experiences, which are suppressed in a patriarchal society (DeVault, 1999).

My first formal learnings about feminism developed during the early years of my undergraduate social work degree. This time in my intellectual and theoretical development was the first step in my reaching feminist consciousness—stage that

feminist sociologists Stanley and Wise (1993) would term ‘discovering feminism’. Prior to this, I was a woman, mother and wife with little understanding of the political nature of my personal experience. My world was being lived before feminist consciousness (Stanley & Wise, 1993), and the questions raised by feminism were both confronting and liberating. I asked myself, in what ways does patriarchy affect my life? Am I really as free as I feel I am? These questions have continued to influence me, long after my textbooks closed and my exams ended. My ‘discovering feminism’ experience of the world opened my eyes to how gender relations and gender dominance influence all aspects of the social world, and it is the reason I chose critical feminist methodology.

Just as there is no single for of feminism, there is no single feminist methodology. As feminist theorist and social worker Lena Dominelli (2002, p. 2) describes. ‘feminism has always contained within its ranks a wide range of divergent and diverse opinions’. Most feminist researchers engage in knowledge building under an ‘umbrella’ of shared values and goals—however, it was important for me to identify my theoretical framework from within the spectrum of feminisms, including liberal, third wave, socialist and radical, to name a few (Dominelli, 2002). Critical feminist research is based on the understanding that women occupy a subordinate position in society because of patriarchal power and control (Devault, 1996), and it aims to reduce gender-based inequality (Rubin & Rubin, 2012). Critical feminism is a social and scholarly movement committed to promoting women’s interests, and is concerned with revealing, challenging and changing dominant ideology. Critical feminist research values women’s lives and strives to bring women’s concerns and their gendered experiences to the forefront of discussion and action (Campbell & Wasco, 2000; Mansbridge, 1995).

One of feminism's core arguments is that the concerns and perspectives of women have often been silenced or ignored, a point I opted to address in my methodological design. I sought to uncover women's experiences and perspectives using the qualitative method of in-depth interviewing and presenting the data in verbatim quotations in a process that feminist researchers DeVault and Gross (2012, p. 176) describe as 'bringing forward neglected voices'. I designed the interviews to be semi-structured and fluid to encourage the participants to lead the direction of the conversation and tell the narrative that held the most meaning for them. As I explain in my methods section, active listening was key to unveiling the stories and experiences of these women, many of whom had not spoken of their perinatal anxiety experience to others.

Feminist researchers have sought knowledge about the subordination of women across a wide range of areas, such as sexual violence (Brownmiller, 1975; MacKinnon 1987), family and caring roles (Harris & Tinning, 2012; Okin, 1989), labour market roles (Bergmann, 2002), reproduction (Firestone, 1970) and motherhood (Rogers, 2015; Neyer & Bernadi, 2011; Jetter, Orleck, & Taylor, 1997). Although their foci and methods of inquiry vary considerably, feminist scholars engage in research that aims to 'start thought' (Harding, 1991, p. 264) and 'begin from the experience' (Smith, 1987, p. 65). Feminist researchers work reflexively and relationally, embracing subjectivity through design, interviewing and analysis (McNair, Taft, & Hegarty, 2008). Critical feminist methodology encouraged me to approach the topic of motherhood and mental health through a lens that problematises perinatal anxiety as an experience of gender inequality. It is with this methodological and theoretical foundation that I aimed to understand the ways in which women are personally and politically silenced by their positioning as women, their roles as mothers and their experience of mental illness.

3.2 Biographical Positioning

[W]ho you are (or are becoming) determines to a large extent what and how you research. (Saldana, 2011, p. 22)

The critical feminist and qualitative underpinnings of my study carry with them the knowledge that my own personal narrative influences all aspects of the research process (Clarke & Jack, 1998). Researcher subjectivity and reflexive awareness occupies a central space in both qualitative and feminist research (Finlay, 1998). My commitment to naturalistic qualitative research and feminist theory meant that subjectivity was paramount in this study. Unlike the positivist paradigm, which actively avoids and rejects researcher subjectivity, a naturalistic approach recognises and explores the researcher's influence on their research (Rubin & Rubin, 2012). Critical theorist Jan Fook (2016, p. 52) argues that 'knowledge, and how we know it, it contextually based'. This context is firmly connected to the researcher, as qualitative research theorist Saldana (2011, p. 22) describes; 'who you are (or are becoming) determines to a large extent what and how you research'. Thus, my 'self' influenced this research. Personal reflexivity is integral to examining the effect my personal experiences and worldview had on the lens through which I undertook this research. Choosing to research perinatal anxiety has a significant connection to who I am, where I have come from and where I hope to be in the future. The personal and political context I exist within has guided my curiosity regarding motherhood and mental health as a social phenomenon. My own lived narratives and the social roles I have filled or been expected to fill represent threads that, when woven together, begin to form a narrative that others can identify with, critique or imitate.

Reflexivity is the process of reflecting critically on oneself as a researcher. It involves reflective self-examination and open discussion (Davies & Dodd, 2002),

interaction with the research and participants (Holloway, 2005) and interrogation of the ways our research is shaped by the paradoxes and contradictions of our lives (Lincoln & Guba, 2004). Achieving quality in qualitative research requires an emphasis on critical and reflexive practice (Seale, 1999; Davies & Dodd, 2002).

However, subjectivity and reflexivity in research have been subject to criticism. Cautions voiced in the literature involve the need for researchers to ‘systematically identify their subjectivity throughout the course of their research’ (Peshkin, 1988, p. 17). Victor Minichiello (1995) argues that reflection and insight are vital when engaging in qualitative work, since research serves to meet the researcher’s personal agenda. At first, I was confronted by the idea that my research might be influenced by my personal agenda. After all, my feminist commitment was to carry out research that gave voice and power to other women—my research was influenced by the agendas of feminism and social work, not by my own desire for personal gain. However, on reflection, I realised that Minichiello is, of course, correct. This research is about advancing knowledge. This research is about promoting feminist and social work goals. This research is about empowerment, consciousness raising and recognition for vulnerable women living with perinatal anxiety. But this research is also about me: my desire to make sense of, and give meaning to, my own personal experience of motherhood and perinatal anxiety, and to connect my lived experience to that of other women.

3.2.1 My story.

Life experience structures one’s understanding of life. (Swigonski, 1994 p. 390)

Motherhood has been, and continues to be, my most profound experience, my strongest sense of identity and my most significant time of growth and change. I was 19 years old when I left girlhood and fell into motherhood. I was also an aspiring actress and first-semester university student, so pregnancy and motherhood represented a

dramatic change of direction. It felt at the time as if the artwork I had been absorbed in creating as a girl had morphed from a colourful stuffed toy to a ‘grown-up’ and practical bedspread. The stuffed toy had been made from threads of youth, friendships, romantic crushes, theatre, emotion, body image, hopes and dreams. The practical bedspread was made from bumpier threads, threads with knots and frays; nonetheless, these threads were (and continue to be) real, strong, colourful and chaotic, woven with the purpose, love, beauty, joy, achievement, tears, despair, frustration and perseverance that have encompassed my role as mother, woman and nurturer.

As my body grew with pregnancy, so did my commitment and love for my child—and when he was born, I recall an indescribable feeling of raw emotion. I looked at him that in that surreal and blurry moment of first breath and said out loud, ‘Oh, there you are!’, as if we were old friends separated for just moments in the pull of a busy crowd. I knew then that I would grow to love my practical bedspread—that the sense of loss I felt for my barely begun stuffed toy would fade. I was right.

The elation, self-pride and inner strength I underwent in the days post-birth were slowly whittled away by the stigma and judgement I experienced in the community and on a broader societal level. Although I was strong, steady, capable and selfless in the eyes of my child, I felt the heat of that stigma and of judgement each time I stepped out from the safety of the nursery. Too many times to recall, I was questioned by strangers regarding my ability to parent given my age, assumed to be single or no longer with the father of my baby and critiqued for being, as a stranger in a pharmacy once said about me, ‘a child raising a child’. To my bewilderment and great frustration, regardless of my actions or intentions, my self-sacrifices, my drive to ‘do it all’ and be a ‘good mother’, the reaction from those around me remained somewhat unchanged and difficult to ignore. Those who knew me supported me, yet at times, it felt as though those who did

not were quick to stereotype and judge me. I interpreted this disapproval as my own failure to impress. I understood the immeasurable pressure I felt to enact what motherhood was supposed to feel like, and had the sense that I was simply not strong/mature/resilient/committed enough to rise to the challenge. It was not until I studied social work at university and later practised in an antenatal clinic that I realised my personal experience was also political—that motherhood is perhaps society’s greatest opportunity to observe, influence and control the thoughts, actions and lives of women. I realised that motherhood had not only rendered me open and defenceless to the feelings, needs, thoughts and actions of my child, but had done the same at a societal and political level. Motherhood had pushed me into the glare of society’s gaze. My flaws, strengths and choices, and those of my child as he grew, were there for all to see.

Mindful of being ‘watched’ by others in my role as a mother, I often hid my difficulties and silenced my own feelings in order to present as a ‘good mother’. I found it very challenging to openly discuss my own feelings of fear, panic, despair or resentment should they render me a ‘bad mother’. I worried that by voicing the thoughts and feelings I was having, I might instead only encourage them to grow bigger and uglier when thrust into society’s view. I kept them quiet for the most part, holding down my internal struggle with the weight of guilt and the magnitude of joy and love I felt towards my child. From that moment, motherhood and mental health became areas that I felt connected to and passionate about.

My personal motherhood narrative intertwines with the practical knowledge I have gained as a social worker in an acute outpatient antenatal clinic. In my work with pregnant women, I have observed discrepancies between the identification and treatment of perinatal depression and anxiety. Depression, it seems, is well understood by both patients and professionals as a risk for the wellbeing of a mother and her unborn

child, and is often taken seriously and responded to with timely intervention. Anxiety does not appear to generate this response. Women are often unaware of the symptoms or risks of anxiety disorders, and professionals tend to consider anxiety secondary to depression or a 'normal' response to motherhood (Matthey, 2003). In my work with pregnant women, anxiety has consistently presented as a primary source of distress and concern. Many of the pregnant women who identify a substance abuse issue have expressed to me that they use substances to numb the debilitating psychological and physical symptoms of anxiety. As a practitioner, I have found few appropriate resources or referral options for women experiencing perinatal anxiety and without a comorbid depressive illness. The dominant knowledge in the field of perinatal mental health focuses primarily on depression or depression with anxiety. The language used and the education and intervention available appear to suit women with 'standard' PND, but not those whose struggle is with perinatal anxiety as a standalone mental health issue. These clinical observations led me to recognise a clear gap in what is understood about anxiety-specific perinatal mental health, and prompted me to question whether such women were living their lives in the margins of dominant knowledge and thus being overlooked.

Consequently, my social work background, current clinical role and, indeed, my own positioning as a woman and mother all contributed to my choice of perinatal anxiety as a research topic. This contextual 'container' of factors continues to influence my research and practice, and is something I can only consciously acknowledge and respect through the careful reflexivity that a qualitative and critical feminist framework allows.

Having described the methodological framework for my study, and the influence of my own mothering and social work narrative, I now explain the methods I used for

recruitment, data collection and analysis. I finish the chapter by considering the ethical and moral challenges I faced during this research, and the limitations of the study.

3.3 Methods

As I have explained in the chapter thus far, critical feminist and qualitative methodologies guided the design of my research study. The methods I employed are informed by both theoretical approaches, and I purposely and selectively chose research ‘tools’ from both that complement the style and purpose of my study. The following sections describe the methods I used for recruitment, data collection and analysis.

3.3.1 Recruitment method. All participants were recruited from the Sunshine Coast Region of South East Queensland, Australia. I chose this geographical area both for practicality and methodological fit. I considered the cost, time and logistics of recruitment and interviewing and decided to concentrate on my local area of the Sunshine Coast. The choice to remain locally focused is also supported in the literature, as research is contextually specific and reflects the social, cultural, political and economic situations of the participants (Stanley & Wise, 2002). The geographical context of this research is the Sunshine Coast, a region of South East Queensland that serves as a residential and tourist location, with substantial rural and rural-residential areas used for dairy farming, crop growing and cattle grazing (Sunshine Coast Council, 2016). The Sunshine Coast is a rapidly growing region located approximately 100 kilometres north of the city of Brisbane. It is known for its popular stretch of beaches, national parks, hinterland valleys and family-friendly tourist attractions. Statistics from the 2016 Census reveal that 5,716 Sunshine Coast residents identified as having an Aboriginal or Torres Strait Islander background: this equals 1.9% of the Sunshine Coast population, whereas the national statistic of 2.8% (Sunshine Coast Council, 2016). The Sunshine Coast region is predominantly ‘white’ and, compared with national

benchmarks, Sunshine Coast residents are more likely to be English speaking, born in Australia and have English, Australian or Scottish ancestry. The Sunshine Coast is a popular destination for retirees and the largest age group in 2016 was that of 45–49 year old residents (Sunshine Coast Council, 2016).

I recruited and interviewed two sample groups. The first consisted of women who self-identified as experiencing anxiety symptoms of clinical significance. These women were either pregnant and/or parenting a child under the age of five at the time of interviewing. I chose to include women whose youngest child was five years or younger to incorporate the experiences of women who could reflect upon a recent, or current, experience of anxiety without losing the clarity of these reflections should too many years have passed. I adopted a working definition of perinatal anxiety to guide my recruitment process. I sought to interview women whose experiences would reflect clinically significant anxiety during pregnancy or in the year following childbirth (Dunn, 2016).

The second sample group consisted of practitioners with professional experience in the perinatal field. My decision to interview both mothers with perinatal anxiety and practitioners was informed by qualitative methodology, where researchers ‘seek to recruit participants who represent a variety of positions in relation to the research topic, of a kind that might be expected to throw light on meaningful differences in experience’ (King & Horrocks, 2010, p. 29). I chose to include the perspectives of practitioners as I felt that their accounts would provide a different slant on how women experience perinatal anxiety, how their experience is linked to broader social and political influences and what future practice and research must address. Recruitment and interviews were carried out over two years, between 2014 and 2016.

I used qualitative methods of purposive and snowball sampling (Patton, 2002) to deliberately seek out participants who could provide insight into the experience of perinatal anxiety. Snowball sampling was particularly helpful as a strategy to recruit anxious women, who are a hidden and isolated group. Snowball sampling allowed me to recruit participants via referral from another source within their network (Patton, 2002)—for example, one psychologist I interviewed passed recruitment information to her clients and thus increased my access to participants who may otherwise have remained concealed.

Qualitative researcher and social worker Padgett (2016, p. 70) advises that '[q]ualitative researchers go where the respondents are, rather than the other way around'. I thus chose recruitment locations that are frequented by women, particularly mothers. I distributed recruitment flyers to online Facebook sites including *Sunshine Coast Kids Stuff for Sale* (14,255 members) and *Sunshine Coast Stuff for Sale* (22,543 members), three medical centres, one Community Child Health centre, two psychology centres, two midwifery services, various childcare centres, shopping centres, primary schools and the local hospital and university.

3.3.1.1 Flyer one: Pregnant women. My initial recruitment flyer was aimed at pregnant women who were experiencing perinatal anxiety. However, despite broad distribution of the flyer and many tentative expressions of interest, only two pregnant women committed to participate. Reflecting on the limited response from pregnant women, I can identify some possible barriers to participation during the antenatal period. First, women who went on to participate in the study often spoke of their pregnancies as a time when anxiety symptoms such as palpitations, breathlessness, nausea and emotional reactivity were largely dismissed by themselves and their practitioners as 'normal' pregnancy symptoms caused by hormones, morning sickness or low blood pressure.

Women also identified a strong reluctance to admit difficulties in coping during pregnancy, particularly when carrying their first child. A review of the literature also reveals psychological literacy (Highet, Stevenson, Purtell, & Coe, 2014; Spedding, Stein, Naledi, & Sorsdahl, 2018), stigma (Moore, Ayers, & Drey, 2016) and screening tools (Matthey, 2003) as potential barriers to women identifying, or being diagnosed with, perinatal anxiety.

Following my difficulty in recruiting pregnant women, I adjusted my method and broadened my search to include women who were pregnant *or* parenting a young child within an experience of perinatal anxiety. Qualitative research academics encourage researcher reflexivity throughout the research process and value the fluid nature of this style of research, which supports adaptation to the twists and turns of social research (Tracy, 2012). Recruiting challenges are commonplace in qualitative studies, and qualitative researchers King and Horrocks (2010) speak of gaining access to participants as complicated by several factors, including researching uncommon experiences, research topics that are painful or emotive and recruiting that requires approval from ‘gatekeepers’. The stigma associated with mental illness most likely affected my recruiting success, an obstacle that required me to approach recruitment with sensitivity and flexibility. I responded to this recruitment challenge by expanding the scope of recruitment with a second revised flyer (for an example of the first flyer, see Appendix 1).

3.3.1.2 Flyer two: Pregnant and/or early parenting women. I responded to the recruitment challenge by broadening the participant sample to include both pregnant women and women who were parenting a child during the first 12 months postpartum. Broadening the scope was successful: a further eight women committed to participate. To capture suitable participants, my second flyer explained what perinatal anxiety could

feel like and asked women, ‘has this been your experience?’ This was a conscious decision, as I had concerns that because of limited societal conversation about the term ‘perinatal anxiety’, women may identify with the symptoms but not with the label itself. In the interest of valuing women as the experts on their situation, I chose not to restrict recruitment to women who had a medical diagnosis of anxiety or PND; rather, I wanted women to identify their own position in relation to anxiety and be the ultimate decision maker in terms of whether they felt they ‘fit’ the participant criteria. This was to avoid a situation in which only women whose anxiety had been validated by a ‘professional’ could participate. I wanted to actively reject the idea of measurement and diagnosis, particularly because perinatal anxiety remains difficult to diagnose and assess (Matthey, 2003). (See Appendix 2 for the second flyer).

3.3.1.3 Flyer three: *Perinatal practitioners*. To recruit practitioners, I created a third flyer (see Appendix 3) using terminology aimed at a multidisciplinary audience of health professionals. I sought to recruit a wide variety of professions that would likely be involved in the physical, emotional and practical care of pregnant and parenting women. I advertised the study at the local university campus and medical centres and with services including Community Child Health, psychology centres, medical associations and midwifery services.

Despite my efforts, advertising at local venues was not as successful as I had anticipated. Literature suggests that recruitment barriers can include limited time, limited understanding, mistrust and fear (Friedman, Foster, Bergeron, Tanner, & Kim, 2014). I believe that although my project was widely advertised, the time commitment required for an in-depth interview was likely a recruitment barrier that affected the willingness of perinatal practitioners to participate in the study.

3.4 Data Collection

Allowing people to ‘talk back’ is a political act that gives a voice to those who have been silenced. (Rubin & Rubin, 2012, p. 9)

In Chapter 4, I introduce the reader to the participants via the first section of the findings. Here, I discuss sample size, the in-depth interview method, questions, and complementary research tools.

3.4.1 Sample size. My recruitment efforts resulted in 13 participants; nine mothers and four practitioners. For a quantitative study, this would be considered a small sample size, but ‘qualitative work is judged more on its freshness—its ability to discover new themes and new explanations—than on its generalizability’ (Rubin & Rubin, 2012, p. 16). I judged my qualitative research on its ‘richness, vividness, and accuracy in describing complex situations’ (Rubin & Rubin, 2012, p. 16), and sought to gain a depth and quality of knowledge and understanding from a smaller number of participants. As with any attempt to achieve quality over quantity, I invested significant planning, time and effort into the interviewing process.

3.4.2 In-depth interviews.

When using single interviews, the onus is on the researcher to make the most of these encounters. (Padgett, 2016, p. 137)

Interviews can be defined as ‘guided question–answer conversations, or an interchange of views between two persons conversing about a theme of mutual interest’ (Kvale & Birkmann, 2009, p. 2). Interviews are purposeful conversations that yield rich data, since participants can describe how they understand the world and their position in it (Tracy, 2012).

In-depth interviewing is a qualitative method used often by feminist researchers to understand people’s lives and experiences and examine complex and hidden social

phenomena (Rubin & Rubin, 2012). For feminist researchers, ‘the traditions of research interviewing have been strongly linked to social justice concerns and projects and the idea of bringing forward neglected voice’, and this potential drew me to the method of interviewing for my own study (DeVault & Gross, 2012, p. 176). Although I offered a second interview for all participants, this was politely declined. Padgett (2016) supports single interviews if they are ethically warranted, such as when researching vulnerable groups, where multiple interviews might be intrusive, upsetting or burdensome. However, Padgett (2016) warns that when using single interviews, the researcher must work hard to ensure they make the most of the encounter. For me, this involved careful planning, rapport building and a range of questioning techniques.

3.4.2.1 Planning the interview. Once a potential participant contacted me to express interest in being involved in the study, I then emailed them an information sheet (see Appendix 4) and consent form (see Appendix 5) to peruse before organising the meeting. If the participant wished to continue, I organised a meeting place and time, with the participant choosing the most suitable date, time and location (Glesne & Peshkin, 1992). Interviews were conducted in participant’s homes (3), cafes or parks (6), workplaces (2) over the phone (1) and, for one participant known personally to me, in my home (1). The interviews ranged in length from 50 minutes to almost two hours; the interviews with practitioners tended to be shorter than those with the women.

Interviews would begin gently to encourage rapport building and a feeling of safety for participants. To build rapport, I used empathic language, transparency and strong ethical practices. I carefully sought informed consent, went to great effort to ensure that women felt as in control of the interview process as possible and clearly explained what would happen to their stories once they were told to me. We would often engage in casual conversation before I began the interview by explaining again the

scope and intention of the research project. This initial ‘warming up’ conversation (Cotterill, 1992) was important in forming a connection with the participant, developing rapport and relieving their feelings of nervousness. This pre-interview conversation lasted much longer with some participants than it did with others, and I noticed that I spent more time on this stage with the participants who initially appeared more nervous or shy. My experience of building rapport aligns with the arguments of feminist scholars who make the point that ‘simply being women discussing “women’s issues” in the context of a research interview is not sufficient for the establishment of rapport and the seamless flow of an interview’ (Kelha, 2009).

3.4.2.2 Questions and content. I began each interview with ‘opening questions’ (Padgett, 2016) aimed at developing trust and rapport and creating a comfortable environment. I asked opening questions about experience, such as ‘How would you say your journey with anxiety began?’ I found that a question such as this would prompt a narrative-style response from the participant, who would often describe their experience from past to present. As the interview progressed, I asked ‘generative’ questions, which Padgett (2016) claims hand control to the participant for setting the pace and creating frameworks for the discussion. When speaking about participants’ suggestions for practice or what they felt they needed during times of struggle, I used ‘posing the ideal’ (Padgett, 2016) questions such as ‘If you had a magic wand and could have altered that experience in any way, what would you have changed?’ These hypothetical questions were useful for gaining insight into the hopes and wishes of participants and for shifting conversation to possibilities for change (see Appendix 6 for my interview guide).

Throughout the interviews, I used careful, active listening skills (Gordon, 1997). I observed participants’ body language, silences, words and gestures and allowed the interview to move in a direction and at a speed set by the participant. When navigating

the flow of interview content, I carefully observed and responded to subtle cues participants gave. By ‘listening deeply’ (Devault & Gross, 2012), I engaged in interviewing that was both responsive and reflexive. Acknowledging the act of listening was useful for me, as I could actively process the interaction and more effectively hear experiences, opinions or arguments that I may otherwise have overlooked. DeVault and Gross (2012) warn feminist researchers of the colonising potential of research should active listening be taken for granted; emphasising the influence listening has on all parts of the production of knowledge. Responsive interviewing and active listening was a vital advantage during my interviews, as I was encouraged to be attentive to unfamiliar experiences and avoid an ‘echo chamber’ effect where I only heard those accounts that resonated with my own experiences and expectations.

3.4.3 Research memos and journaling. Reflexive research sits comfortably alongside qualitative and feminist methodology. It is now widely accepted that reflexivity is a ‘crucial strategy in the process of generating knowledge by means of qualitative research’ (Berger, 2013, p. 220). This shift from the demanded objectivity of positivist research has urged researchers to consciously acknowledge, record and analyse their assumptions, experiences, actions and decisions (Mruck & Breuer, 2003). Reflexive research involves purposeful reflection on one’s positioning and how personal characteristics, experiences, values and beliefs influence the lens through which we view the world (Berger, 2013).

I found journaling an important method of reflexivity that contributed depth and richness to my research design, methodology, methods and analysis. I used journaling as a way of ‘unpacking’ my thoughts after each interview, navigating ethical and moral challenges, and making sense of the project data and direction. Journaling is common practice in qualitative research, and is considered a reflexive tool to enhance the

transparency of qualitative research. Michelle Ortlipp (2008) writes of her experience with reflective journaling during her postgraduate study, arguing that her use of this method not only enhanced methodological rigour, but also challenged and changed the research process itself. By documenting her thoughts, choices and experiences over the course of her research, Ortlipp achieved a depth of understanding that improved her research transparency and broadened the knowledge generated from her inquiry.

Another scholar, Ruth Behar, used confessional and autobiographical journaling with illuminating and rich results in her qualitative study 'Translating Women' (Devault & Gross, 2012). Acknowledging her thoughts, feelings and observations gave Behar's data and findings authenticity and encouraged true immersion in the data for deep analysis.

The following is from a journal entry I wrote after interviewing a participant:

A murky boundary line rests between the role of researcher and the role of social worker. This confusing blur of values, aims, responsibilities and purpose have become a steady source of ethical questioning and critical reflexivity for me during interviewing. I feel such personal and private pain belongs more in the therapeutic warmth of a social worker/service user interaction than one between researcher and participant. I'm often leaving the homes of women feeling an enormous sense of empathy, powerlessness and determination. Empathy for strong and resilient women who bravely shared their experiences of pain, fear and desperation. Powerlessness at the limitations of my researcher role in providing therapeutic care for these women within this setting; a contrast to my practitioner role where the stories of vulnerable women would be not just heard but responded to in a practical, acute and visible sense. Determination to pay true homage to the stories of these women, to value them and nurture their meaning in all aspects of the research.

As the journal excerpt describes, I found myself questioning the effect of my interviews on the women, and was taken aback by the guilt or responsibility I felt when women shared painful experiences for the first time in the interview setting. I connected strongly with Newman and Henderson's (2014, p. 144) idea that 'the relationship between researcher and research participants involves power and trust ... (and) comes with a responsibility to guide, protect, and oversee the interests of people he or she is studying'. This journal entry gave me a place to document and 'digest' the conflicting experience of qualitative interviewing. It also served as a point of further analysis and theoretical strengthening as I sought out literature that could make sense of my experience. The journaling process encouraged me to remain conscious of my 'self' in the research and embrace my emotional reactions as part of the construction of knowledge, and as a tool for reflexivity and theorising (Gilbert, 2000).

3.5 Thematic Analysis

I used a thematic analysis approach to make sense of the research data. Thematic analysis provides a 'method of identifying, analyzing, and interpreting patterns of meaning ("themes") with qualitative data' (Clarke & Braun, 2017, p. 197). I chose thematic analysis for its flexible approach to analysis and ability to be applied using a critical theoretical framework; I asked myself what the data told me about the women's experiences and the nature of their oppression.

I analysed the data using an inductive, data-driven approach: I identified themes from the data and aimed to develop a rich description of the data rather than a detailed account of one aspect (Braun & Clarke, 2006). To explore the experience of perinatal anxiety I wanted to identify and analyse themes at an interpretive level, where I could theorise patterns within the themes and consider broader meanings and implications.

Qualitative researchers Braun and Clarke (2006) suggest that this style of analysis is particularly useful when exploring an under-researched area such as perinatal anxiety.

3.5.1 Looking for themes. I began looking for themes during the interview process.

When listening to the women speak about their experience of perinatal anxiety, it became clear that certain issues played a major role in their narrative. I made a mental note of these key points and later recorded them in my journal to revisit when interviewing the next participant and coding the data.

This initial search for emerging themes was cyclical and fluid. It was a reflexive process of theory building, whereby ‘the researcher visits and revisits the data, connects them to emerging insights, and progressively refines his/her focus and understandings’ (Tracy, 2012, p. 184). This process is similar to collecting the pieces of a puzzle: as I listened to the stories of the women, I began connecting their narratives to previous interviews, literature, my own personal and clinical experience, and broader socio-political concepts. At times, I found that pieces of narrative would fit effortlessly with others, whereas some pieces seemed an odd fit to the ‘puzzle’ I was building. Braun and Clarke (2006, p. 89) note that ‘it is important to retain accounts that depart from the dominant story in the analysis’—therefore, I worked to identify and acknowledge the pieces of the puzzle that I felt did not fit easily into the developing concepts. I then revisited these early observations when I transcribed the interview data.

3.5.2 Listening again. Once I had completed my interviews, I transcribed the audio recordings verbatim. This process again formed part of the overall thematic analysis. Qualitative researchers value the act of transcription as ‘a key phase of data analysis within interpretive qualitative methodology’ (Bird, 2005, p. 227). As I listened again to the women’s narratives, I noticed subtle themes that I had overlooked during the initial interviews. Braun and Clarke (2006, p. 87) refer to this process as ‘familiarizing

yourself with the data’. Again, I documented these observations for later reflection when developing codes for the analysis. This recursive style of analysis meant that I revisited the data and literature many times to identify strong themes in the narratives.

3.5.3 Coding: Making sense of the data. Once I had familiarised myself with the interview data and established initial concepts, I moved to the coding process, for which I used NVivo software. I entered the transcribed interview data into NVivo and read carefully through each transcription again, manually linking words or sentences to different ‘nodes’ or categories in a process of ‘organising ... data into meaningful groups’ (Braun & Clarke, 2006, p. 88). I identified 34 nodes (see Appendix 7) from the initial rereading of the interview transcripts. However, as my immersion in the data continued, many codes were merged together under an overarching node that more accurately portrayed the emerging theme.

3.5.4 Identifying themes. Once I had coded the transcribed interview data, I refocused my analysis from nodes to themes (Attride-Stirling, 2001). This involved sorting the different nodes into potential themes—for example, I connected the nodes ‘coping’, ‘self-esteem’, ‘emotions’, ‘stress’ and ‘perfection’ under the theme of ‘Warning Signs’. As Braun and Clarke (2006) recommend, I used visual tools to navigate theme development by creating mind maps in NVivo (see Appendix 8) to assist in forming connections between different nodes. This process resulted in five key themes and multiple subthemes. Lastly, I reviewed the themes and subthemes against the data to ensure accurate representation of the narratives and to depict the complexities of the women’s experiences.

3.6 Trustworthiness and Rigour

The credibility of a qualitative research depends on the ability and effort of the researcher. (Golafshani, 2003, p. 600)

Rigour is a critical concept for qualitative research, as it establishes confidence and trust in the research findings (Thomas & Magilvy, 2011). In qualitative research, rigour is achieved by creating rich knowledge through addressing subjectivity, connecting through research relationships and reaching completeness (Buchanan, Wendt, & Moulding, 2014). Qualitative scholars Thomas and Magilvy (2011) note that the term ‘qualitative rigour’ is an oxymoron, as the strict boundaries of scientific rigour does not naturally fit with the flexible, responsive style of qualitative research. Despite this conflict, the trustworthiness of qualitative research remains paramount.

Qualitative methods of ensuring rigour and trustworthiness in research can include member checking, peer debriefing and reflexivity (Thomas & Magilvy, 2011). As discussed earlier in this chapter, reflexivity was an important part of my methodological approach to the study: I engaged in reflexive journaling and peer debriefing with friends who are mothers and practitioner colleagues, and with another social work PhD candidate, to discuss emerging themes and reflect on gaps, assumptions or inconsistencies. To establish the credibility and trustworthiness of my analysis, I used member checking to ensure that my representations were accurately presented. To achieve this, I asked participants if they could assist with member checking, and one participant from the sample group of mothers agreed. The participant reviewed sections of her interview transcript and the written findings. This participant gave me positive feedback on the authenticity of my work in terms of representing her experience of perinatal anxiety.

3.6.1 Ethics approval. Ethical integrity is vital for safe, transparent and morally sound research. As Wiles (2013, p. 9) states, ‘ethical issues are often unique to a specific context, the management of such issues nevertheless needs to be informed by a range of ethical frameworks, approaches, regulation and guidelines’. This project received Ethics

Approval: H6117 from James Cook University (see Appendix 9) and was rated a category 3 because of the vulnerability of women experiencing anxiety and the potential risk of their distress. To address these potential risks, I was required to provide the Human Research Ethics Committee with details of my clinical experience and training in identifying and responding to emotional distress and risk of harm. Each information sheet provided participants with the contact details for a 24-hour counselling service should they experience any post-interview distress. The information sheet (see Appendix 4) and consent form (see Appendix 5) were approved by the Human Research Ethics Committee to ensure participants' knowledge of the research purpose, the confidentiality of their information and their consent.

3.6.2 Doing ethical research. Mindful of the oppressive potential of research with vulnerable groups (Gorelick, 1991), feminist researchers are ideally cognisant of the political nature of research, the power imbalances present and the 'need for and ethical commitment to the individual participants and the larger population' (Kilty, Felices-Luna, & Fabian, 2014, p. 4). To discuss ethics, I adopt sociologist Anne Ryen's (2016) view on the three main areas of ethical concern: consent, confidentiality and trust. Ryen argues that research ethics are based on an epistemology that is incompatible with most qualitative research. This is because ethical research practice as understood by many governing bodies is a concrete approach that conflicts with the complex and fluid social world being explored through qualitative means. Ryen (2016, p. 35) contends that qualitative work achieves ethical adherence through its methods and epistemology, where 'guidelines, courses and literature, experience, and discussions with colleagues, supervisors and respondents/co-researchers, may prepare us for moral practice'.

3.6.3 Consent. Informed consent is 'the provision of appropriate information to enable people to make informed decisions about participation in a research project' (Wiles,

Heath, Crow, & Charles, 2007, p. 11). Although this appears to be a simple step in the research process, qualitative methodology can pose challenges for ensuring informed consent. Qualitative scholars have raised concerns about the ‘fit’ between the standardised ethical requirements of consent and the complex reality of qualitative inquiry (Miller & Boulton, 2007). In their qualitative study, Dixon-Woods and colleagues (2007, p. 2,219) identified inconsistencies in the way participants understood written participation information and concluded that ‘people may make sense of information about medical research, including the content of written information, in complex and unexpected ways’. Others have argued that ethical practice for informed consent is context specific (Small, 2001; Goodwin et al., 2003) and must be managed reflexively to address issues of information, consent and competence (Wiles, Heath, Crow, & Charles, 2007). These arguments highlighted the fact that I should not assume participants would read and comprehend the information and consent forms. To minimise potential confusion, pressure or misinformation on the part of participants, I took a feminist approach to gaining and maintain consent. I approached informed consent not as a static ‘tick box’ requirement, but as an ongoing factor that needed to be negotiated between participants and myself throughout the research process (Miller & Bell, 2012).

I provided initial information via the recruitment flyers. When a participant contacted me to express interest in the study, I emailed a copy of the Information Sheet and Consent Form and a short description of what their participation would involve—for example:

Thanks again for your interest in participating, it would be fantastic to meet up with you and hear about your experience. I’ve attached an Information Sheet and Consent Form for you to have a look at. Basically participation involves an

interview (with a second follow up interview if you are happy to) which is a relaxed conversation style discussion about your experience of anxiety during pregnancy and/or post-baby. Your details are kept secure and confidential and any direct quotes from you that I use in the end thesis will be de-identified. The interview is audio-taped so that it can be accurately transcribed into text but these audio tapes are also kept secure and confidential.

If at any time before/during/after the interview you decide you want to withdraw your information you can do so without any problem.

We can meet up at a place and time that suits you best and if you have your child/children with you on the day that's perfectly okay too!

Let me know if you have any questions or concerns and send me an email if you would be happy to participate and we can organise to meet up!

Thanks again,

Zalia

When I met with each, participant, I verbally outlined the research purpose and aims and reiterated the content of the Information Sheet and Consent Form. I encouraged the women to raise any concerns or questions at any time during the process.

3.6.4 Confidentiality. Confidentiality is a vital component of ethical research, but can be problematic when researching vulnerable groups (Gibson, Benson, & Brand, 2012). Gibson et al. (2012) acknowledge the complexity of confidentiality when reflecting on their research into suicide. They note that confidentiality may need to be compromised should the participants raise issues during the interview that could result in harm to themselves or others. This was important for me to consider in my study when

informing participants of the limits to their confidentiality. I navigated this complex issue by remaining transparent with participants and explaining that their confidentiality would be maintained wherever possible, but cautioning that in extreme circumstances, I may need to inform appropriate authorities should a serious risk of harm become apparent.

3.6.5 Trust. Building and maintaining trust was an important part of my study. Ryen (2016) emphasises the importance of trust in the relationship between researcher and participant, and argues that researchers have a responsibility to provide a positive research experience for participants so as not to spoil the field for others. Trust was particularly important in my study because of the vulnerability of the women I interviewed (Hammersley, 1993). Because of the stigma and silence surrounding mental illness, it would be expected that trust be an integral part of sharing difficult narratives with a stranger. In their research on gender violence, Skinner, Hester and Malos (2005) found that participants were wary of confidentiality breaches and how their stories would be used in the research. In my experience of interviewing the women, I found that rapport building and transparency was critical to building trust. I invested time in creating a comfortable and safe environment for conversations to unfold and reiterated that the women were free to disclose as little or as much of their story as they felt comfortable. I approached trust building from the perspective of Glesne and Peshkin (1992, p. 106), who argue that ‘friendship is not an essential condition for conducting research; being accepted and trusted is’

3.7 Reflections on Research Relationships

Building and nurturing relationships is a core skill of social workers, and is often the key to meaningful therapeutic outcomes. Research relationships are viewed as a vital part of feminist-focused research since, as Caroline Ramaznoglu (1992, p. 211)

states, 'it is more logical to accept our subjectivity, our emotions and our socially grounded positions than to assume some of us can rise above them'. Both feminist research methodology and social work values and frameworks view research relationships as pivotal to quality, transparent and ethical research.

Despite their importance, research relationships can also present moral and ethical challenges. At the beginning of my research project, I felt sure of the role, purpose and benefits of therapeutic relationships within social work practice. However, once I began to interview participants, I found the role of these relationships occasionally confusing and contradictory. I saw my dual roles as perinatal social worker and social researcher intrinsically linked and difficult to separate. For example, during one interview, a participant described not knowing where to find help for her perinatal anxiety, and I felt myself wanting to slip into social worker mode and provide information, a referral and other therapeutic input. Balancing women's wellbeing and consciousness raising with the purpose and goal of the interview was thus particularly challenging.

Interviewing vulnerable groups has been the focus of much feminist discussion, with feminist researchers such as Mkandawire-Valhmu, Rice and Bathum (2009) describing similar difficulty in separating research from practice and balancing the provision of emotional support for vulnerable women while continuing to steer an interview towards its purpose. Reflexive research can examine power imbalances, which are significant for social researchers using a feminist lens.

Reflexivity was very valuable for me during this process. It greatly helped me navigate the often complex, unpredictable and messy nature of interviewing humans. I feel that it was especially relevant in this area of research because the interview content was highly sensitive, sometimes raw and potentially emotionally unsettling for

participants. Strong reflexive practice allowed me to critically examine the way in which I prepared, planned, conducted and risk managed the interviews to reduce and respond to potential ethical and moral issues.

3.8 Introducing the Participants

To introduce the participants, I begin by recognising the importance of privileging women's everyday lives in social research (Smith, 1987). I began my research journey with a desire to know more about the topic of perinatal anxiety. I could have chosen many ways to approach this topic: I could have formulated surveys or only used 'expert' practitioners as my source of knowledge. However, I chose to use the voices of women as my source of knowledge. This decision was influenced by critical feminist theory and feminist and critical social work frameworks (Payne, 2005). I share my reasoning here to explain the importance of women's voices as the source of knowledge for this research.

As I have explained in previous chapters, feminism continues to influence the contemporary landscape of social research, with the emergence of research that seeks out the lived experiences of women to better understand certain phenomena (Moyzakis, 2004; Wardrop & Popadiuk, 2013). Feminist research has revealed contrasting views of motherhood that challenge the dominant ideals portrayed in the public realm through a commitment to investigating and challenging power relationships, oppression and inequalities (Choi, Henshaw, Baker, & Tree, 2005). I chose critical feminist theory as the foundation for my research because it aligns with my desire to understand perinatal anxiety from the perspective of women's lived experiences. Critical feminist theory provides a theoretical framework that identifies the complex contexts of women's lives, uncovering dominant social discourses that act to shape and discipline women's behaviour and treatment (Payne, 2005). This framework

encourages the researcher to seek out and value women's stories as legitimate knowledge that can inform understanding. A feminist research approach values the unique voices of women and holds women's knowledge as critical to comprehending the effects of gender inequality (Geisinger, 2011), recognising the ability of individual and collective stories to make visible women's experiences so that social and political constructions can be changed (Oakley, 1981). Feminist standpoint theorist Dorothy Smith (1987) argues that domination operates in the 'everyday/everynight lives' of women, which has implications for women practitioners as well as mothers.

My background as a social worker has also influenced my desire to hear women's voices themselves. My feminist social work framework is grounded in a practice approach that seeks to address social and structural inequalities by connecting women's personal experiences to the broader structural and political constraints of patriarchy. When seeking to enhance my knowledge of perinatal anxiety, my social work framework and values supported my choice to interview women about their experiences. By seeking out women's knowledge, I could undertake research that validated and gave power to their lived experience and sought to empower them through recognising their expertise (Payne, 2005).

3.8.1 The women behind the voices. I interviewed nine women who self-identified as experiencing perinatal anxiety during their motherhood journey. The women represented a diverse group in terms of socio-economic status, relationship status and age. However, despite the extensive recruitment efforts I explained in the methodology chapter, no participants came forward who were part of a minority group such as Aboriginal or Torres Strait Islander women, culturally or linguistically diverse women, women with a disability or those in a same-sex relationship. This is important to note, as the women interviewed thus represented a privileged group. In speaking about the

challenges of feminist research methodology, Ramazanoglu and Holland (2002, p. 142) warn that ‘targeting gender can have the effect of excluding, silencing or marginalizing significant divisions between women, and empowering the research to privilege gender over other differences’. Therefore, it is important to acknowledge that the women in my research do not speak on behalf of all women, and may describe an experience that differs from that of other women whose societal positioning is further complicated by race, sexual orientation or disability.

The women who volunteered to participate were all born in Australia except for one, who had immigrated from England. They varied in age from early twenties to late forties and had differing education and career backgrounds, ranging from those who were unemployed prior to motherhood and had not completed secondary education, to those who had postgraduate qualifications and worked as health professionals or business women. Of the nine women, six were married and three were separated or divorced. Table 3.8 introduces the mothers who participated in the study. To ensure confidentiality, I have given the participants pseudonyms.

Table 3.8.1: Participants

| | |
|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Carmel | Carmel is a white Australian woman in her thirties. Carmel is married, has a tertiary degree and is employed as a nurse. Carmel is mother of Harrison, who is 18 months old. |
| Rebecca | Rebecca is a white Australian woman in her forties. Rebecca is a social worker and has completed a tertiary degree. Rebecca is mother to Harry (nine) and Toby (five). |
| Tanya | Tanya is a white Australian woman in her twenties. Tanya is separated from her partner and studies full time at a tertiary level. Tanya is mother to Rosie (three). |
| Louise | Louise is a white Australian woman who is currently a stay-at-home mother to her children Jessica (six) and Mia (two). Louise is separated from the father of her first child, Jessica, and is a single parent |

| | |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | following the death of her partner (Mia's father). |
| Simone | Simone is a British woman in her forties who is separated from her partner. Simone has a postgraduate qualification and works in the education sector. Simone is mother of Katie (five) and Corey (two). |
| Courtney | Courtney is a white Australia woman in her thirties. Courtney is married and works in the disability sector. Courtney is mother to Sienna (two) and pregnant with her second child. |
| Dana | Dana is a white Australian woman in her forties and has completed tertiary education. Dana runs her own business and is mother to Jasper (six) and David (two). |
| Miranda | Miranda is a white Australian woman with a tertiary qualification. Miranda is in her thirties, works as a social worker and is mother to Chloe (two) and pregnant with her second child. |
| Sophie | Sophie is a white Australian woman in her twenties. Sophie is married, tertiary qualified and employed as nurse. Sophie is mother to Tamika (three) and Sarah (one). |

3.8.2 The politics of representation. Alongside the voices of the women, I chose to explore the practitioner perspective of perinatal anxiety to gain insight into the therapeutic approaches and belief systems of those who support women through their anxiety experiences. By speaking to both practitioners and women with perinatal anxiety, I aimed to investigate both public and private accounts to establish context and add depth. In keeping with my feminist approach, I included the 'public' accounts of perinatal anxiety from practitioners to examine their connection with or disconnection from the 'private' accounts of the women (Ribbens & Edwards, 1997). Aware of the potential power imbalance between practitioners and mothers, I included the practitioner voice with caution, as I wanted the mothers I interviewed to be viewed as the ultimate experts in the perinatal anxiety experience. Feminist researchers D'Arcy, Turner, Crockett and Gridley (2011, p. 31) warn of power of representation in research, stating, 'we must be intimately aware of the implications of how we represent others in research, and the risk within some methodologies of reinforcing power inequalities'. With this in mind, I caution the reader to view the practitioners' perspectives as adding

layers to our understanding of perinatal anxiety, rather than justifying or validating the women's experience. The truth as I see it can only be found in the expert voices of the anxious mothers.

3.8.3 The practitioners. I interviewed four health practitioners: a midwife, a social worker, a psychologist and an obstetrician. All of them were women, which is important to acknowledge, as their perspectives, experiences and professional status were also influenced by their position as women. As radical feminist Denise Thompson (2001, p. 92) argues, 'some women are in a dominant position in relation to other women ... some women oppress other women because they are more privileged than other women. The practitioners' perspectives are thus shaped by the male-centric medical model they work within and by their own oppression as women. Table 3.8.3 introduces the practitioners who have been given pseudonyms to ensure confidentiality.

Table 3.8.3: Practitioners

| | |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Brenda | Brenda is a senior obstetrician employed in a public hospital setting. Brenda provides care to both gynaecology and obstetrics patients. |
| Maria | Maria is a senior midwife employed by Queensland Health in the community setting. Maria provides perinatal care for women and is an educator for tertiary-level midwifery students. |
| Gina | Gina is an early-career social worker employed in the public hospital setting. Gina works in the antenatal and maternity field and provides perinatal care for women. |
| Lucinda | Lucinda is a psychologist and runs a postnatal mental health clinic that provides private psychology for perinatal mental health care. Lucinda has 11 years' clinical experience in perinatal mental health. |

3.9 Conclusion

This chapter has described the methodological foundations of my exploration of women's lived experiences of perinatal anxiety. Qualitative and critical feminist methodologies and theory guided my approach to this project, informing inductive

research that valued women's expert voices and provided rich and meaningful data about the experiences of perinatal anxiety. In keeping with a critical feminist methodology, I also reflected on my own biographical positioning and how my narrative shaped my inquiry into perinatal anxiety.

After establishing my methodological approach, I described the methods I deployed to explore the experiences of perinatal anxiety. I used in-depth interviews as my method of data generation and complemented this approach by keeping a research journal, which increased the depth of my engagement in the data-generation process and informed early analysis. I used the qualitative method of thematic analysis to make sense of the data and develop key themes and subthemes from within the narratives; the thematic analysis resulted in five key themes. To ensure trustworthiness and rigour, I used qualitative methods of reflexivity, peer debriefing and member checking to ensure the authenticity of my representation of the women's narratives. I acknowledged the complexity of conducting ethical research with vulnerable groups and reflected on the challenges I faced when navigating research relationships with vulnerable women.

I have concluded this chapter by introducing the participants who took part in my research and justifying my methodological choice to focus on the voices of women. I have acknowledged issues of power and the politics of representation.

I now turn to the first of the findings chapters: 'Good Motherhood'.

Chapter 4: Good Motherhood

When reflecting on the early experiences of motherhood, the women I interviewed described the challenges that triggered or increased their vulnerability to perinatal anxiety. In this chapter, I present the first of my core themes; ‘Good Motherhood’

I noted in previous chapters that the good motherhood discourse profoundly influences the lived experiences of mothers. As I conducted the thematic analysis, I found that the good mother ideology was woven through the experiences of the interviewed women and the perspectives of the interviewed practitioners. I present the findings for ‘Good Motherhood’ using the following subthemes: what are good mothers made of?, letting down the motherhood and social media: friend or foe?

4.1 What are good mothers made of?

All of my anxiety was about being a good mum pretty much. Just wanting to do the right thing by him. (Rebecca)

Despite the women referring often to the ideal of the ‘good mother’, it was not clear what a good mother actually looked and behaved like—she was a murky and unachievable figure. Good motherhood was something to which the women aspired, but struggled to define in specific terms. Good motherhood ideology is historically and socially situated, and therefore changes over time. As feminist sociologist Smart (1996) describes, the ‘rules’ of good motherhood have shifted, and contemporary good motherhood discourse has expanded from the physical needs of the child to the psychological care and nurture of the child. Whereas mothers in history were held to expectations of children being well fed, clean and physically healthy, contemporary mothers are also judged by their ability to ‘love *properly* and to express this love in the

correct fashion' (Smart, 1996, p. 47). The women's stories revealed this script of good motherhood, to which they found themselves held after becoming a mother.

4.1.1 Sticking to the script.

Sexism begins with motherhood. (Dana)

Sticking to the script of good motherhood was an unspoken expectation the women faced once they were mothers. For example, Dana described a significant shift in her expected role and behaviour as a mother:

I remember, Harry was only like a month old, and I had a friend come over and I said to her 'Oh my god, I've only just realised, like, sexism begins with motherhood'. It just puts you in your role. The mother gets no break. The husband goes to work and probably gets to have a coffee and sits around and has time to himself. A mother, who is at home with two small children, gets nothing. And she's so exhausted that she actually needs to sleep, you know? I'm always the one that's awake. I think that's what led me to having that really bad sleep deprivation, that feeling that I could do it all. That I should be able to do it.

Dana identified new motherhood as a moment when she recognised her oppression based on her sex. Having left her autonomous job as a business owner, Dana was met with the reality of motherhood as a devalued and tightly constrained role. This experience aligns with the view of Pitts-Taylor and Schaffer (2009, p. 11), who argue that women are 'shocked to find that as soon as they birth, a barrage of social, economic, and institutional structures position them into a second-class unpaid status' (p. 11). Dana's experience of motherhood as being 'put' in a role speaks to women's disempowerment as mothers, when their lives become relegated to the private realm of

motherwork—an experience critical theorist Nancy Fraser (1989, p. 117) describes as ‘the confinement of women to a separate sphere’.

Midwife Maria also spoke of the social script for mothers, and noted the disparity between parenting responsibility for mothers and fathers:

There’s huge pressure. If anything goes wrong it’s always the mother’s fault, it’s never the bloke’s fault, it’s always the mother’s fault. Women who sit across from me in that office down at the (health centre) they’re nodding their heads when I’m saying that and say ‘That’s true, it’s always my fault. He’s half the relationship. It took half of him to make the baby ...’ Where’s the fairness?

Where’s the equity in the world? I’m sorry but the glass ceiling just got higher.

Maria’s perspective reveals the requirement that mothers ‘perform gender’ in line with societal expectation (Butler, 1990). Good motherhood ideology values intensive mothering, and therefore supports the notion of women mothering alone without the need for assistance or support from husbands or the broader community. As anthropologist and women’s health researcher Tapias (2006, p. 88) argues, a child’s health and happiness serve as ‘vehicles through which social, medical and legal judgements are made regarding ... maternal care giving practices’. Mother-blame serves to strengthen such ideology by placing full responsibility for children’s wellbeing, development, happiness and success on mothers.

4.1.2 Living up to maternity. When referencing good mothers, the women identified the importance of maternal feelings. Good mother ideals were intrinsically connected to the women's sense of being maternal, and to be a maternal woman was vital in achieving good mother status. The women acknowledged anxiety about their deviance from these expected norms:

I always felt quite anxious about my opinion of motherhood. I wasn't one of those 'It's awesome I'm pregnant, I can't wait'. I was like 'I'm never going to sleep again'. I was very pessimistic about it. (Dana)

As Miranda described, despite being acutely aware of the importance of maternal behaviour, she was not sure what being maternal looked or felt like:

I can't even give a definition of what maternal would be, I don't even know what that is or what that means. You will persevere with breastfeeding, even if your nipple is literally dropping off? You will let your kid bake with you? I've got friends who would just happily have 50 million kids and they're cruisy and they're great and they paint with their kids and stuff. For me to paint with Chloe I have to psyche myself up for a couple of days to be like 'We can do this'. Like, I'm not a maternal, super affectionate ... well, no I am affectionate, that's not the word. I'm not one of those 'mummy mummies'.

The 'mummy mummies' to whom Miranda referred are the poster women of intensive mothering. Feminist scholar Sharon Hays (1996) coined the term 'intensive mothering' and defines it as an ideological force that expects mothers to place their child's interests ahead of their own, devote their lives to meeting their child's physical, emotional and cognitive needs and experience mothering as a fulfilling and sacred experience. Those who meet, or attempt to achieve, intensive mothering standards are

judged as better and more maternal than their mother peers. As Tanya explained, fear of judgement drives the desire to maintain intensive mothering standards:

The pressure is that if you don't say that it's perfect and the best thing every day then people will think that you don't love your kids and you're not a good mum. There's all that pressure of people thinking that maybe you're neglectful if you mess up sometimes, like if you give your kid two-minute noodles two nights in a row. You feel like you're failing the child and that the child could do better. That, you know, because everything the child does is on you. There's this whole idea of what a mum should be and it's not realistic, it's not possible to live up to, so lots of the time you're just feeling inadequate.

Tanya's story indicates the internalisation of ideology that Thompson (2001) argues is central to maintaining patriarchal control. Thompson (2001, p. 22) defines the experience of living under domination as maintained because 'women (and men) accept the reality of their position, embrace it as natural and unalterable, desire its continuation and fear its destruction, and believe it is their own meaningful existence'. Thus, despite her own tentative rejection of the unrealistic expectations of motherhood, Tanya perceived dominant ideological norms and her subsequent feelings of inadequacy as expected and unalterable. Critical theorist Jan Fook (p. 101) refers to this internalising of ideology as 'complicity with oppression' - the act of seemingly engaging in behaviour which works against their own best interests. As feminist scholar Kate Kirkpatrick (2014, p. 281) asserts, 'many mothers believe it is not "feminine" or "motherly" to struggle with motherhood, which perpetuates the problem because the struggling mothers don a mask that shrouds frustration and confusion safely away from the outsider's view'. This argument helps make sense of the pressure Tanya felt to portray motherhood as 'perfect' to other mothers, and to society at large, in what

Friedan (1963, p. 7) refers to as ‘a strange discrepancy between the reality of our lives as women and the image to which we are trying to conform’.

4.2 Letting down the motherhood

It's just that pressure to not let down the motherhood. (Tanya)

Tanya's description of ‘letting down the motherhood’ is central to good mother ideology, which expects women to mother naturally, selflessly and without error. When women do not meet these unachievable expectations, it is ‘seen as a personal, unnatural and moral failing’ (Malacrida, 2008, p. 100). As the women in my study explained, the pressure to meet the expectations of motherhood is profound:

Whether you work or whether you're a stay-at-home mum, I think the pressure is just huge. (Dana)

I think most women want to be the best mother that they can be, and in wanting to be the best they can be there is a sense of anxiety around that as well. There's a lot of expectation and a lot of guilt that goes with it which again exacerbates anxiety. There is so much pressure on a pregnant woman to be successful, to only have gained 12 kilos, to be going back to work as well as breastfeeding, as well as bringing in the money, as well as keeping the house tidy, as well as entertaining on the weekends. (Gina, social worker)

It's more, I don't know, I suppose you worry ... I think it's just that pressure to not let down the motherhood, to let other people who don't have kids know that you're not these amazing people all the time. (Tanya)

Simone described her feelings of guilt at being a ‘bad’ mother during her struggle with perinatal anxiety:

I was a bad mother at that time. I know now that it probably wasn't my fault but I was a bad mother. I was screaming at my kids, I know that's wrong. But I didn't know what else to do. I needed help and I didn't get it. And I wasn't the one that suffered, my kids were.

Guilt is profound for many mothers who experience mental illness (Perera, Short, & Fernbacher, 2014). Since mental illness does not fit within the ideals of 'good' and 'intensive' mothering, women can feel as though they are deviating from the norm. Simone's story indicates the internalisation of motherhood ideology and the subsequent guilt and self-blame this causes.

4.3 Social Media: Friend or Foe?

Media and entertainment have been regarded as important sites of broad social and political change since the work of radical feminist Betty Friedan in the 1960s. Therefore, it is not surprising that social media and 'mummy' blogging have become a focus of contemporary feminist discussion. As I outlined in the literature review, mummy blogging is viewed by many as a radical act that challenges dominant motherhood ideology often represented in other forms of media (Lopez, 2009). Mummy blogging has been linked to the consciousness-raising groups of second-wave feminism, where collective sharing of women's everyday lives has the potential to reveal systemic inequalities and break down the mystique surrounding motherhood (Van Cleaf, 2015). Despite this potential, mummy blogs do not necessarily result in maternal consciousness raising, and can even reinforce dominant motherhood narratives. Feminist scholar Van Cleaf (2015) argues that mummy blogging relies on 'resilience narratives' that shift the focus from broad social and political inequalities to overcoming personal difficulties. The sharing of women's private lives can be stripped of the capacity to achieve political

and social change if narratives are individualised and separated from their broader context of oppression.

Online communities can thus be both empowering and debilitating for mothers. Online communities offer convenient and easy to access to peer support, resources and emotional connection (Valtchanov, Parry, Glover, & Mulcahy, 2014); but some studies have found that online communities can exacerbate women's anxiety by prompting them to compare themselves with others (Hicks & Brown, 2016). The women in my study spoke of their conflicting experiences with social media, positioning it as both friend and foe.

4.3.1 Friend. For some of the women, social media was a helpful resource for navigating motherhood. For Dana, it created an opportunity for learning and connection:

I think in some ways it's great because it does connect people and can be helpful. Or you're reading something else that someone's doing whereas maybe before, if you were just kicking around with your neighbours and their kids you wouldn't know.

Dana's experience reflects the findings of a study by McDaniel, Coyne and Holmes (2012), who found that mothers who used social media experienced improved wellbeing and feelings of connection. Social media can provide an alternative community for mothers, resulting in emotional support, sharing of experiences and information, and reassurance and validation regarding the experience of mothering (Hall & Irvine, 2008).

Tanya spoke about reading the work of mummy blogger Constance Hall, whose honest portrayal of motherhood made her feel reassured and empowered.

Reading about it can help. Like, that Constance Hall lady, it's just nice to hear from someone, it doesn't really matter who, that you can mess up on a daily

basis and your kids will still be okay. Just to let the pressure off so you don't have to do it right every day. I suppose it's that honesty thing. If everyone was honest about how it feels for them then we'd all feel a lot more supported and there wouldn't be that image to live up to. Like that Constance lady is doing, uniting the Queens, supporting other mums and trying not to judge. It seems like she's helped a lot of people with that sort of thing, she's got a huge following. You see that it's pretty normal to feel that way.

As Tanya noted, raw and honest depictions of motherhood can challenge dominant ideology by providing counter narratives that have transformative effects on readers, defining and redefining their identities and shaping their understanding of their experience as mothers (Orton-Johnson, 2017). Hall's blog represents what feminists such as O'Reilly (2010) would term 'maternal empowerment': mothering that challenges the norm. Maternal empowerment is promoted by Hall's blogging in a number of ways. Hall questions and critiques the expectations to which mothers are held by society, arguing that mothers do not only feel love and joy for their children, and challenges mainstream parenting 'rules'. Hall encourages maternal empowerment through her efforts to transform her own mothering experience into social and political change, an act of maternal activism (O'Reilly, 2010).

For Courtney and Carmel, online communities became primary sources of support:

I used a pregnancy and new mum group on Facebook and that helped a lot.
(Carmel)

My biggest support was Facebook. There's a hip dysplasia support group and I did join that page. People get on there, they're all from around the world, and

they comment on their babies. I remember that when I got on there and joined the group I got a heap of support. (Courtney)

4.3.2 Foe.

I've needed to be really careful about social media because that hasn't helped my anxiety and my view of my own mothering. (Miranda)

Social media is not always a liberating resource for mothers: the women in my study also identified social media's oppressive and anxiety-provoking nature. While it gives women better access to information and social connection, social media can also increase the comparison and competition of motherhood and reduce women's confidence and self-esteem (Chae, 2014). Social media is thus a paradox, exposing mothers to both opportunities for empowerment and experiences of further oppression.

I think it's like this industry that creates a lot of this anxiety around parenting, whereas 30, 40 years ago, when no one had any idea or there wasn't all of the stuff. It was more handed down from parents and we weren't held to these really high, kind of, like your child should be sleeping at this time and that time.

Rather then, some kids don't sleep during the day. (Dana)

For Dana, the overwhelming amount of information available through social media reinforced mothering expectations that were neither achievable nor realistic. Dana's experience can be explained by the work of researchers Madge and O'Connor (2006, p. 200), who argue that 'online discourses and practices continue to reflect and reinforce the unequal gender power relations'. Miranda's experience with social media was also one of comparing herself with other mothers:

I've needed to be really careful about social media because that hasn't helped my anxiety and my view of my own mothering. Because, if I step away from that I'm like 'Yes, I don't mother like this person but you know what? I actually

do believe I'm a damn good mum'. I love Chloe, I provide for her, she's certainly attached, developmentally she's where she needs to be. When I look at that I think we are doing well. But then I look at social media and I go, I don't want to paint with her. I'd rather pay somebody, send her to daycare so they can paint and play Playdoh with her because that just, that drives me nuts.

For Miranda, social media served as a reminder of the 'good mother' expectations that led her to question her own position as a good mother. This experience can be understood as social media reinforcing normative motherhood ideology through criticism and judgement of those who do not conform to dominant societal expectations (Orton-Johnson, 2017). As feminist theorists Maureen Engel and Caitlin Fisher (1997, p. 33) argue, 'women's experiences with the net do suggest opportunities to tell new stories, but these exist alongside some key familiar master narratives'. For the women in my study, social media was considered a foe when these master narratives of 'good' and 'intensive' mothering overwhelmed their experience of social media, thus affecting their experience of perinatal anxiety. Social media can therefore reinforce patriarchal ideals of motherhood by portraying mothers as good, natural, intensive and perfect in the same way that Friedan's (1963) happy housewives were blinded by the feminine mystique. Midwife Maria spoke of the oppressive nature of social media for women:

Social media's out there and it's condemning women all the time if they don't follow this incredibly narrow path. How limiting is that? It's cruel, it's cruelty, it really is. The cruelty to women is still profound out there.

Psychologist Lucinda also noted the anxiety-provoking nature of social media: I think the anxiety amongst women is increasing with the instant sort of media on everything. A lot of their anxiety or intrusive thinking is about safety and they get highly vigilant and they also get very sensitive to the news and things

happening to children, so that can become quite intrusive as well and quite sensitive to other children being hurt.

Lucinda's observations connect with the findings of recent research into the links between social media use and anxiety. Although perinatal anxiety-specific research in this area is absent, studies have shown connections between the use of social media and increased anxiety disorders (Vannucci, 2017). This is thought to be driven by a number of factors, including exposure to stressful and distressing events in the lives of others (Hampton, Rainie, Lu, Shin, & Purcell, 2014) and negative feedback from other social media users (Valkenburg & Peter, 2009).

4.4 Conclusion

In this chapter, I have presented the theme of 'Good Motherhood'. Women spoke of good mothering as a set of unachievable, yet desirable, ideals that shaped their experience of mothering and perinatal anxiety. The women in my study struggled to articulate what good mothers were made of, but indicated that a strong social script of motherhood was central to good motherhood ideology. The good motherhood script transitioned women into a role constrained by social, economic and institutional structures. With their lives relegated to the private realm of motherwork, the women found themselves playing a new role for which the script was already written and tightly controlled.

A key part of this script was the concept of maternal feelings. Again, the women were unsure of what maternal women represented, but knew that maternal feelings and actions were vital to good motherhood. For the mothers in my study, maternal women were those who mothered intensively and instinctively, baked and painted with their children and enjoyed devoting their lives to the activities of child-rearing. The women experienced guilt, self-doubt and confusion when they felt they may not have been

maternal enough to meet the standards of good motherhood, and these feelings were tightly bound to the experience of perinatal anxiety.

The women spoke of the pressure to not let down the motherhood, and described feeling responsible for upholding the dominant ideology of motherhood. Failure to maintain this dominant ideology was experienced as a personal and moral failure.

Social media was experienced as a conflicting influence on the women's mothering. It expanded access to support, information, friendships and social connection and challenged the dominant ideology in a manner that was refreshing and liberating; for some of the women, it also resulted in raising their awareness of the constraints of motherhood and offered counter narratives to good mother discourse. However, social media also reinforced the dominant ideology and left the women feeling judged, inadequate, overwhelmed and filled with self-doubt.

I now turn to chapter five where I will present the next finding: 'Warning Signs and Cries for Help'.

Chapter 5: Warning Signs and Cries for Help

Based on my analysis of the data, the experiences and perspectives of the women and practitioners led me to identify an overarching theme of ‘Warning Signs and Cries for Help’. To establish this broader theme, in this chapter, I explore the subthemes that emerged from the data: pregnancy and birthing, irritable baby, medical issues, isolation, relationships, lack of support, financial stress and home environment.

5.1 Pregnancy and Birthing

I was tearing and they cut me and then they had to suck her out. (Sophie)

Women’s experiences of pregnancy were spoken of as influencing emotional wellbeing and mothering identity, and many were shrouded in feelings of powerlessness, guilt, disappointment and dissatisfaction:

My birth experience wasn’t pleasant. It was a long labour and I ended up needing, um, and I ended up needing to have an epidural and I didn’t want that I had wanted to have a water birth ... but I knew that probably wouldn’t happen. And he was just so stuck and I couldn’t, my labour wouldn’t progress and so he ended up being vacuumed out so it was just a long time and I was pretty disappointed. I had watched my sister have her baby—I’m a nurse—and she had a beautiful experience and I was just disappointed that I didn’t have something as nice. (Carmel)

I ended up with pre-eclampsia and was induced with her so I ended up with a really long, stressful delivery which took me a long time to recover mentally and physically from. I had her vaginally but it was epidural, episiotomy, tearing, stitches. It was everything. It was all the things that I didn’t want to have happened. I never thought I had a massive plan of what I wanted my labour to be

but I guess it just wasn't that. They induced me on the Monday night, the Monday afternoon, and I had her the Wednesday morning. I did hours and hours without an epidural and then I got one and then it failed so I had to get another one and then, yeah then she started getting stressed and then I was tearing and they cut me and then they had to suck her out. It was, it was too much for me to cope with. (Sophie)

Sarah Rushing (2015), a political feminist theorist, argues that women's experience of birthing is laden with political and ethical questions. Considering birth culture in the United States, Rushing contends that a woman's labour and delivery is a political site with the potential to constrict and control women, or to empower them through political awakening. Rushing (2015, p. 531) views birthing through the lens of humility and autonomy, which she posits is complicated by the 'increasingly medicalized, technocratic, and consumerized' act of childbirth. Sophie's and Carmel's birthing experiences speak to the medicalised nature of childbirth, and exemplify Rushing's argument that women are socially conditioned to defer choice and control to authorities and experts during birthing. Sophie's labour induction and Carmel's 'failure to progress' can both be viewed as examples of birthing that were controlled and driven by a strictly medicalised environment. Rushing (2015, p. 531) would argue that in Sophie's and Carmel's birth experiences, both women had their control and autonomy diminished for the sake of policies and procedures that favour a normalised birthing regime:

a woman who wants to make choices about her care that exceed the narrow set of options sanctioned as normal and reasonable is figured as lacking humility and is marginalized, disciplined, and even stigmatized as a bad mother. A woman's desire to self-determine her own priorities for a good birth, for

example, by resisting medical interventions or opting out of the hospital altogether, are framed as self-centered and irresponsible, not as a form of health citizenship and educated agency.

Sociologist and professor of women's studies Karin Martin (2003, p. 54) further contributes to the theorising of women's birth experiences, arguing that 'women and their bodies are controlled and disempowered by social institutions during childbirth'. Martin asserts the need to consider the external and internal ways in which gender informs women's birthing experiences by disciplining their bodies. Based on Martin's argument, Carmel's and Sophie's compliance during birth, even when choices were made that went against their wishes or needs, was shaped by powerful, internalised gender norms. For Martin, women internalise a gendered expectation of childbirth that requires them to comply with the recommendations of medical experts—thus placing the infant or expert, rather than themselves, at the centre of birth—and withhold their true needs and feelings.

Alongside the medicalisation of birth and subtle oppression of women's choice and control is what Malacrida and Boulton (2013) refer to as the moral imperative. Carmen's and Sophie's shock and disappointment at the medically intrusive nature of their births can be understood as a sense of failure: 'the moral imperative to give birth naturally means that women who are unable to achieve this are likely to feel as though they have failed' (Malacrida & Boulton, 2013, p. 44).

The practitioners also revealed the significance of birth for women, and the subsequent trauma many women experience when their expectations go unmet. Social worker Gina detailed women's fear of birthing, which is often the result of other women's traumatic experiences:

In the setting of the antenatal clinic I've found that anxiety is a predominant issue amongst all of the ladies that I see. Particularly for ... the first-time mums, they are told horror stories. I think for some reason other women like to share their horror stories, their horror birth stories, so you have this new mum who's becoming more and more terrified and I guess it's their friendship groups, or anyone they come across, is happy to share their horror story.

Rushing (2015) describes these horror stories as birth narratives that compromise women's autonomy during labour, resulting in increasing numbers of women who face birth both unprepared and anxious. As Rushing (2015, p. 538) states, women's powerlessness and fear are 'reflected in birth narratives that describe shock, terror, isolation, and importantly, as a simple Google search will show, the words "I would have agreed to anything at that point"'. Women are therefore primed to fear birth, and to prepare handing over control and choice, even before they feel the first labour contraction. Many feminists have argued that the medicalisation of childbirth supports dominance over all aspects of pregnancy and birth and limits women's control and choice (Kukla, 2005; Oakley, 1984).

Midwife Maria further explained the connections between birthing, control, expectations and women's experience of anxiety:

The birthing seems to be the big thing ... the whole focus. I try to let them know that it is just one day in your life, sometimes it extends, but mostly it is just one day in your life and you probably need to think about the here and now. Most women are just fearful that they will lose control in the environment of birthing when all the control is taken away from them and their body takes over. You can't show them the videos of that you know, because that's just too shocking. So, you've got to prepare them for the worst and hope for the best. It's that same

scenario that you do with anything that's going to be a traumatic period in your life. For those women who end up having a vacuum extraction or still able to have a vaginal birth but have had to have medical intervention like forceps delivery or have had to have an episiotomy, which is a real surgical intervention which is done often at the last minute with very little plan or very little information, it can come as a big shock. It's frightening, and they feel totally helpless. It's very traumatic. If she has to have a general anaesthetic, then she has totally lost all control. And afterwards it's taken away, all the birth plan, that's totally gone. So, their expectations are just torn apart and that can be, for a lot of women that can be incredibly traumatising.

Loss of control during childbirth has been explored by researchers such as O'Hare and Fallon (2011), who identify control as an important factor in shaping women's experiences of birthing. The history of birth reform activism is also concerned with women's choice and control during birthing. The 'first wave' of birth reform activism arose in the early twentieth century and encouraged women's access to pain relief during labour (Rushing, 2015). This fight to access pain medication was followed by a second wave of reform, during the 1960s and 1970s, which challenged the medicalisation of birth and called for women to be given opportunity for 'drug-free' birthing.

More recently, birth plans and personalised midwifery care have become popular, with woman asserting their preferences prior to birth, a time when their choice and control will be reduced. Despite the intended role of birth plans to increase women's control and choice, as Maria noted, birth plans are often not met because of what Rushing (2015, p. 537) argues are 'dominant values surrounding birth ... efficiency, convenience, and extreme risk avoidance—outcomes over process'. If a

woman's satisfaction with her birthing experience is directly related to a sense of control (Green & Baston, 2003), then it is not surprising that women undergo feelings of shock, distress and trauma when that control is completely lost. Malacrida and Boulton (2013) warn that birth plans create an illusion of individual choice and responsibility for women who are birthing within a set of structural and social conditions that do not support true choice and control. In their qualitative study on the experiences of childbirth, Malacrida and Boulton (2013) found that women's birth plans were rarely realised, and led to a sense of responsibility and guilt when the birth did not occur as hoped. Malacrida and Boulton attribute this feeling of responsibility and guilt to the assumption that women are responsible for ensuring the health of their child and the success of their birth plan, the implication being that the woman is to blame should birth expectations not be met. Malacrida and Boulton argue that birth planning discourse acts as a form of governmentality, giving women an illusion of empowerment while in fact disciplining them by rendering them responsible for their birth outcomes despite the power imbalances that exist in the labour room.

5.2 Irritable Baby

I guess it was just what ifs. What if she stays awake all night? What if she's hungry and I can't feed her? What if she cries a lot and I can't stop her?
(Sophie)

Mothering an irritable or unsettled infant was a key source of anxiety and struggle in the women's lives. Irritable infants have been linked to women's feelings of incompetence as mothers (Cutrona & Troutman, 1986; Megel, Wilson, Bravo, McMahon, & Towne, 2011), and are considered a significant risk factor for high levels of postnatal anxiety (Christl et al., 2013). Both the women and practitioners spoke in

detail about the effects of practical difficulties such as feeding and sleep on the experience of anxiety and motherhood.

5.2.1 Feeding. Feeding difficulties presented significant challenges for many of the women. As Courtney described, feeding issues resulted in substantial stress and worry during her early experience of motherhood:

She was very colicky, colicky can be from what I've learnt can have two meanings; either they're not dealing with their environment or they're very windy. I believe that maybe it was because of the Caesarean and not because of being windy because she was born via a Caesarean and ... she was dairy intolerant as well which we had to work out ourselves. She just wouldn't stop screaming and then I just started cutting things out of my diet. But it was a month of intense screaming, just all day long and then I did end up back at hospital because things just didn't seem right and she was going downhill.

Carmel articulated her feelings of responsibility for her son's feeding and the distress it caused her:

Food was a huge form of stress—and I'm a nurse but I wanted to be there if anyone was feeding him I would be very ready to, because sometimes I would have to scoop things out of his mouth and he would be gagging and gagging and then everything that he'd eaten would come up and he wouldn't touch food then. And I was thinking if you're not going to eat then you're not going to sleep so I thought that was going to compound our sleeping issues if he wasn't getting enough food. Food was definitely an issue.

Dana spoke about her escalating anxiety and panic surrounding the feeding of her second child David, linking his poor eating to feelings of failure and distress:

I think there's different triggers for people depending on the child. Like, eating is a massive one for me because I would get so obsessed cause I'd see these kids, these toddlers, just sitting there eating a sandwich and I was like, I can't get him to touch that you know? I was a mess, I became so anxious I couldn't actually feed him. I had never had a panic attack in my life, and I just ... literally, every time I went to feed him I just, I just couldn't do it. I started shaking, I had to leave the room. And we're all meant to be on this holiday and it's supposed to be fun and our friends are American so we're having this Thanksgiving lunch and she had her one year old there and her little girl eats everything. And every time I saw her just eating and I couldn't get David to eat anything and I'd just be walking out of the room crying, coming back and trying to keep it together, walking out of the room crying.

Sophie also described being overwhelmed, and identified a cascade of worries about her ability to meet her child's needs:

I don't know, I guess it was just what ifs. What if she stays awake all night? What if she's hungry and I can't feed her? What if she cries a lot and I can't stop her? James was like 'Let's just deal with right now, if she's hungry we'll feed her and if she needs a nappy after we'll deal with that when that comes'. But I just couldn't separate it all, like, I don't know.

For many of the women, breastfeeding was also a major source of anxiety:

He ended up having a tongue and lip tie so I had breastfeeding issues, he was only small when he was born, only five pound nine and I had no milk so he ended up having formula first, so I was pretty disappointed. The breastfeeding really upset me and created a lot of anxiety. Prior to having him I thought if I could [breastfeed] I would, if I couldn't so be it ... but as soon as he was here I

was hell bent on breastfeeding I was so just determined to do it. Breastfeeding did become a fixation. I couldn't go out in public with a bottle, I just was, yeah just made me feel like I wasn't ... I said to Todd, 'he doesn't even need me, I can't even breastfeed him, he doesn't even need me'. I went through so much.
(Carmel)

Carmel's experience of breastfeeding speaks to the influence of good mother ideology. Carmel's sense of failure and uselessness is clearly expressed in the above quotation: she placed full responsibility and blame on herself and her body for her breastfeeding struggles. This sense of failure can be linked to strong societal affirmation of breastfeeding as 'natural' and 'superior' to bottle feeding (Crossley, 2009), which suggests that mothers who do not, or cannot, breastfeed are deviating from good mother expectations. This is evident in Carmel's sense of shame for bottle feeding, which kept her from revealing her child's feeding to the public, a comment that implies her awareness of public opinions about how good mothers feed their infants. Dana revealed the difficulty she had giving up breastfeeding her son, indicating an internalised pressure to nurture her child in a particular way:

For me, giving up breastfeeding, I couldn't do it. Even though I could see, he doesn't mind the (formula), it's okay for him, but I couldn't do it. And I didn't have that with Jasper at all. I think because his food thing made me so ... I knew that food was a problem for him but with Jasper I didn't know. Even then, I kept thinking 'No, I can't eat that because even if I'm stopping breastfeeding what if I'. That was probably the most ... yeah, that's when the anxiety really kicked in on this level.

Dana self-monitored her behaviour and choices even when she could objectively identify her own conflicting opinions on the 'best' way to feed her son. This self-

monitoring behaviour reflects the internalisation of ideologies described by radical feminist theorist Denise Thompson. Thompson (2001, p. 47) argues that ideology acts as a hidden force of oppression in women's lives; a 'calculated falsehood which suppresses consciousness of alternatives'. Women then internalise such ideology as truth. Even though, at times, the women recognised that their thoughts, feelings and behaviours had alternatives, they felt unable to stray from the ideological rules of motherhood.

Louise also spoke of the external pressure she felt to breastfeed her baby, and how this challenged her own beliefs about feeding:

Even the nurses, they're like 'No, you need to breastfeed' and they're straight onto you and they're touching your boobs, you know, doing all this. And I never thought that ... I thought 'If I can breastfeed I can, if I can't, I can't. Who cares?' That was the way I was.

Tanya, who was in her early twenties when her daughter was born, spoke of the judgement and criticism she received for breastfeeding, poignantly highlighting the lasting effects of this experience on her confidence as a mother:

There's a lot of judgement because of my age I think. I mean, the midwives were pretty abrupt and rude and the issues with breastfeeding was obviously causing anxiety, not being able to feed her. I still need to make a complaint. I think at the time, because you're told about the 'baby blues' that you're going to be emotional and your hormones are all over the place. So, when she [lactation nurse] said, or suggested, that I couldn't ... that I wouldn't be a good mum if I couldn't feed my baby I didn't feel like I could say anything because I thought maybe I was being emotional. Now, now I think that she should be fired. Or at least talked to, because she obviously made a judgement in thinking that I was a

lot younger than I am and she obviously put her own judgement on me suggesting that I was too young to have a baby and that I couldn't do my washing; she had no idea that I'd been living out of home for five years. She made it [anxiety] a lot worse because she made that judgement. It has still really stuck with me. That idea that she thought I couldn't cope. That I wouldn't be able to cope because I was having trouble feeding her. I mean that sticks with you in that you think 'Well if I have trouble with anything then maybe I'm not capable'.

Tanya's story, and that of the other women quoted here, is consistent with the societal expectations placed on women in their role as 'nurturer' and the dominant view of what a 'good mother' does. Breastfeeding is a mothering action that has been subject to much contentious debate in the public realm and, indeed, within feminist discussion. Some have argued that the push to breastfeed has forced women into an interdependent relationship that ultimately exposes them to criticism, shame and surveillance (Taylor, 2012). In feminist circles, concerns have been raised that the pro-breastfeeding movement is an 'ideological move to bring the maternal body into greater cultural regulation through breastfeeding' (Hausman, 2011, p. 92).

The stories of the women highlight the role other women play in maintaining patriarchal ideology. As Louise and Tanya revealed, their experience of breastfeeding was shaped by midwives whom they felt were dominant, controlling or judgemental, thus reflecting the notion that 'an individual may be an oppressor, a member of an oppressed group, or simultaneously oppressor and oppressed' (Hill Collins, 1991, p. 225). Although midwives are predominately female and likely mothers themselves, they hold significant power as medical 'experts' and can reinforce dominant ideologies that further oppress other women (Hill Collins, 1991).

The shame and guilt women experience around breastfeeding ability or choices can also be understood through a critical feminist lens. A critical view of women's shame and guilt is connected to the power imbalance between mothers and practitioners, which is reinforced through the privileging of dominant expert discourse that views practitioners' opinions as 'truth'. The individual responsibility placed on mothers by their neoliberal environment demands that they make choices for their child that result in optimal physical and psychological development (Williams, Donaghue, & Kurz, 2012). This expert discourse represents the 'best' or 'right' choices for child raising and mothering, placing mothers in a disempowered position where alternative decisions will be viewed as deviant and negligent.

Infant feeding has become medicalised to the point that Tanya, and indeed all mothers, care for their children under the expert instruction of doctors, midwives and lactation consultants. As Bartlett (2002, p. 376) contends, 'while institutional policy requires the mother's docility as a patient to accept expert authority and instruction it is still the mother who is constructed as inadequate—both by herself and her educators—when breastfeeding is not successful'.

Practitioners Gina, Lucinda and Maria all spoke of breastfeeding difficulty, expectations or judgement as a risk factor for anxiety in the postnatal period:

I think there's that expectation that the baby will be born and go straight to the breast like in all the images that you see and everything that's discussed during pregnancy is that 'breast is best for your baby'. And you point out to mothers that this is the norm. That around 80% of women have to really work at breastfeeding, and that it doesn't just happen. (Gina, social worker)

Like Gina, Lucinda raised the importance of acceptance and normalisation for women who could not, or did not, breastfeed their infants:

A lot of the mums in the [therapy] groups didn't breastfeed. And that's very important for the hospitals to know. I would love it if the hospitals could have a look at the research and see what is the correlation between a woman's experience in hospital and postnatal depression and anxiety. That (birth or feeding trauma) would come up, I would say, with nearly every single woman I see in the groups and individually, that experience or maybe that attitude of staff in the hospital around breastfeeding or just the general care of the mum. The sensitivity around that. They often feel like they are failures if they can't breastfeed, um, and you know so we're very careful in this clinic that there's no judgement around whether they can, or even whether they want to. The main thing is just that they feed them.

Maria also identified the pressure placed on women to breastfeed their infants. Maria's experience of being a midwife for mothers who have a professional background as a doctor or general practitioner (GP) is shared here:

Any woman who is finding breastfeeding incredibly traumatic, either physically or emotionally. I even say this to doctors. I've had GPs and doctors come and see me in that setting and saying 'I think I just needed permission from another professional'. And I say 'It's okay, you've done your best. What more can you do? You're giving yourself a guilt trip'.

5.2.2 Sleep. Sleep was considered a key stressor by the women, who described the corrosive effects of sleep deprivation on their psychological wellbeing and enjoyment of mothering. Perinatal sleep deprivation is recognised as a risk factor for developing low mood (Armstrong, Haeringen, Dadds, & Cash, 1998; Hall et al., 2009). However, sleep is often considered a purely biological need. Interestingly, the women characterised sleep as a skill that 'good' mothers could master, a view reinforced by the multitude of

sleep resources available for women. As Carmel and Dana explained, sleep was more than a physical need and was accompanied by feelings of failure:

I feel that my sleep deprivation was a huge, huge factor and clouded so much of my judgement. Just being so, so tired. After I had him I did a lot of research about sleep. My chiro put me onto the *Save Our Sleep* book and I can totally see how people get quite anxious about it because you think 'My baby didn't sleep for the two hours she said it would and I've done everything she said'. (Carmel)

And for the first couple of weeks and I thought 'Oh okay, this is good' and then David's reflux kicked in, and he just never slept, like that kid never slept. And then, I think, it's such a double-edged sword, isn't it? You're a little bit anxious and then all of a sudden you get no sleep and then this happens. I would be like 'Am I ever going to get sleep again?' 'Am I ever going to sleep again?' so it made me not enjoy it. I found it really hard and I found I'd get really quite bitter with these women who had these babies and were like 'Oh he's just been sleeping through for six weeks and I don't know ... maybe you should read this book or maybe ...'. (Dana)

Carmel and Dana identified sleep as a skill that mothers could, and should, obtain. Their experiences reveal the pressure to be an 'effective mother' (Marshall, 2014). Good mother ideology expects women to be 'natural' mothers with the intuitive ability to meet their child's care needs. For Dana and Carmel, their infants' sleep issues were viewed as a sign of personal failure or incompetence. This 'natural mother' discourse (Brown, 2006) places women in a position of inadequacy, guilt and anxiety when they perceive themselves as failing at their biological role and lacking instinctual mothering knowledge.

Both women indicated that expectations around sleep only fuelled their desperation and anxiety, a view reinforced by psychologist Lucinda:

So, we're also finding that the women who are buying or engaging in sleep experts, those sort of things, and trying to stick by what's coming up in these books. Some of the books are really good, but some of them are written by non-experts, and so we've got a lot of women coming here, especially the ones with anxiety, and they've bought those books and their newborn's not sleeping through. So, then there are these unreal and unmet expectations and that 'If my baby's waking up every two or three hours, what am I doing wrong?'

Miranda and Simone spoke of the effects of sleep deprivation on their emotional wellbeing and relationships:

Not sleeping and stuff that anxiety does increase. Now my anxiety is more how am I going to cope with Chloe and the new baby? And again, knowing what a toll that took on Stuart and my relationship. That lack of sleep. This time I'm going to be even more sleep deprived and how's that going to ... because lack of sleep just drives me bonkers. (Miranda)

Corey was the worst baby imaginable. He was awake between seven and twelve times every single night, did not have a sleep pattern at all. Would not respond to anything I tried, screamed the place down when we had neighbours all around us. I was a mess. I was sleep deprived. In 16 months, I never slept more than three hours in one go. I never got the option to sleep. I used to fall asleep at the desk trying to study and he'd wake me up and I'd have to go and sort him out. I was just back and forwards all night I never really went to bed. People would have conversations with me and I was there for it then my head would just be gone. Yeah, I was a mess. Just an absolute mess. (Simone)

5.3 Medical Triggers

I couldn't avoid the problems. (Rebecca)

Medical triggers were spoken of as contributing to the mothering experience and increased levels of anxiety. The key medical issues raised by the women and practitioners focused on baby's health and development and pregnancy loss.

5.3.1 Baby's health and development. For Courtney, her baby's health and development consumed the first year of motherhood. Courtney's daughter was diagnosed with hip dysplasia, and Courtney explained the effect of this diagnosis on her anxiety:

No one actually ever said ... 'She could have a whole year of ultrasounds, she could end up in a brace ... um ... this is really what's wrong with her'. She was diagnosed at four months and went in to the suit. It was a huge shock. I felt a bit dumb. That morning before we went to the hospital she rolled but then once in the suit she could only lie on her back on the floor, she couldn't roll. The first week was so horrible, just crying constantly, and her crying because she couldn't get comfortable in it. And I never let her cry, um, whilst wearing it. I always held her. The first week was so horrible that any time after that could not compare to that first week.

Courtney felt unsupported and alone following her daughter's diagnosis:

I didn't get a print out about the suit, I had to get the information myself. Why didn't they say that you should bring someone to this appointment with you?

They were just so vague all the time. I mean is it the public system? Is it just the way things are handled? I was seeking support whilst she was in the suit and there just wasn't any. I saw the GP regularly for reassurance. I wonder why I

wasn't educated the first time around, like, was it because they didn't want to scare me just in case? But then the 'just in case' happened.

Courtney spoke of people's reactions to her daughter's condition, and hinted that she actively avoided exposing her child's medical suit to others in a clear desire to avoid the critical gaze of a society that values healthy and happy infants and ties normative expectations of children to their mother's effort, efficiency and success. Leading feminist writer in motherhood studies, Andrea O'Reilly (2010, p. 17), describes the 'impossible standards of idealized motherhood' that oppress, discipline and disempower women in their role as mothers. Idealised motherhood demands mothers have children who do not challenge such standards, an ideological force that can influence women's feelings of failure when their children do not fit within dominant societal expectations:

Luckily it happened in winter so I could dress her in sleeping bag suits and that way if we went out no one knew. Sometimes she could only wear a t-shirt if it was a warmer day and so the bottom of it (suit) was hanging out, so if I went into a shop it was easier to put her on my hip, I'd get comments like 'Oh the poor thing' or 'What happened?' or 'Cool boots, oh they're not boots what's on her legs?'

Courtney articulated the grief and guilt she experienced and the pain that comparisons with other babies caused her:

I think I get more sad about it now [starting to cry]. Um, I think I'm worried about this one [current pregnancy]. I'm not sad for me, I'm sad for her. That she had to wear it. Like we went to mums' groups and all the other babies were sitting up and crawling and she wasn't. I just wanted to take it off her straight away.

Courtney also identified the uncertainty her daughter's medical issues created:

She's still not in the clear until her x-ray when she's five, there is a chance of regression. They can regress. We almost have to wait until she's five.

Courtney was not alone in her experience of medical issues contributed to her anxiety—other women shared their experiences of how they were affected by medical concerns:

It was 12 weeks when it [anxiety] started full on, she was 12 weeks old and then she also had whooping cough, so yeah it was pretty full on. (Louise)

There was always an issue with Toby, whether it was his eyes and there's a problem there so we're at a specialist in Brisbane, or his feeding ... like he was really vomiting and I would think is he lactose intolerant? You know, so there's all these ... like you create your own problems ... I couldn't avoid the problems. And then they, he was a late roller and a late crawler and all of that, and I was okay with that because there was so much else going on ... then they referred me to the development clinic at the hospital where they see an OT [occupational therapist] and a physio and all that ... around 'He's not doing this quick enough' and then they referred him to a speech therapist because he wasn't ... and I thought, really? Is this really a problem? But then that created the anxiety. (Rebecca)

Psychologist Lucinda also reflected on the role of medical issues on women's risk of developing anxiety, or having it exacerbated:

The other contributing factors are that the baby might be quite unsettled or have some health issues. Premmie babies, or twins, or IVF that always pushes it [risk] up more. Babies who are sick and having problems.

For Tanya, Carmel and Rebecca, a fear of potential medical issues or delayed development caused anxiety:

Anxiety over her health and SIDS [sudden infant death syndrome] and everything, SIDS is like a major ... they make such a huge big deal out of it and that's okay but for people with anxiety that's just all you think about for the first year at least. I was in denial about the fact that there would be a baby at the end of the pregnancy, convinced something would go wrong or that it couldn't actually be happening, yeah. I suppose there was heaps of anxiety about her health and her labour and if something would go wrong in the labour. (Tanya)

Once we'd eliminated every possible health issue with Toby I was like, right what's wrong with Harry now ... [laughs]. You know, I remember having that thought with all the tests that Toby was undergoing and all the scans, thinking 'Do I have Munchausen's? Am I traumatising my child? Is this about me?' (Rebecca)

You worry the whole time about things don't you? Their development and all that. He didn't roll for ages. I didn't join a mothers' group for that reason because my friends had told me it's just competitive. (Carmel)

The women's fear of medical or developmental issues represents the discourse of intensive mothering that underpins good motherhood ideology. Intensive mothering encourages women to place children's needs ahead of all else (Hays, 1996) and demands that mothers maintain close physical and social proximity to their infants and children (Francis, 2012). This master narrative of intensive mothering pushes women to construct their emotional and social lives around their child's health, happiness and success (O'Reilly, 2008). Francis (2012) argues that intensive mothering makes women susceptible to stigmatisation and blame should their child's health, development or

behaviour not meet normative expectations; this was experienced by the women quoted in the following section who underwent pregnancy loss.

5.3.2 Pregnancy loss. Pregnancy loss was an experience shared by Carmel and Simone, who described the consequences as elevated anxiety and feelings of grief and loss:

I had a miscarriage before him, and so our early stages of pregnancy ... and we had tried for over a year, um, so my early stages of pregnancy I was trying to be calm but I don't know that I was all that calm and I had a Doppler so I could listen to the heartbeat and stuff. My husband and mum were like 'You don't need to do all that' but it just kept me calm, I could find his heartbeat and then I was fine. (Carmel)

Carmel's experience of elevated anxiety and desire for reassurance following her miscarriage speaks to the traumatic nature of pregnancy loss. Anxiety, depression, grief and post-traumatic stress disorder are common for women following pregnancy loss, with emotional distress contributing to future pregnancies (Berth, Puschmann, Dinkel, & Balck, 2009; Bicking Kinsey, Baptiste-Roberts, Zhu, & Kjerulff, 2015). Simone spoke about her experience of pregnancy loss and the emotional distress that followed it:

I got pregnant straight away with twins and lost them. At about 10 weeks I lost them and I was absolutely devastated, absolutely devastated. I got pregnant straight away after the miscarriage, um yeah lost them had to go for an operation in the January and he was born in the November so yeah straight away he came. They told me at first that it was an ectopic pregnancy, that he wasn't happening, that they couldn't find him. I went back in again at 10½ weeks and there's a baby. So, that was the start of my pregnancy. And so soon after losing the

babies. I had lost two but I was getting one, and you can't be unhappy for the one you're getting but you've just lost two. (Simone)

Miscarriage is also a gendered experience, felt and experienced differently by different women. Pregnancy loss is more than a physical loss, with many women undergoing a sense of fear, guilt or incompetence after miscarriage. This trauma, informed by motherhood ideologies of 'naturalness' and an expectation of women's innate purpose to reproduce, can influence women's sense of self and lead them to doubt their bodies and their womanhood (Layne, 2002).

5.4 Isolation

It's actually quite lonely being a mum. (Courtney)

Isolation emerged from the data as a key experience for the women. As Courtney noted, her expectations of motherhood were not met, and she found the role lonely and isolating:

You see it on TV, like *Offspring* and that. And it's not actually like that, it's actually quite lonely being a mum. Even though I have the park and the beach and I had a difficult baby so I was pretty busy anyway. I was very worn out.

Dana also identified feeling isolated and aloneness, characterising this as an experience shared by all mothers:

I think that we're so isolated now. So even if we have friends and stuff nearby, we're so isolated.

Louise spoke of isolation and a sense of guilt for her daughter possibly missing out on socialisation. Louise felt pressure to build broader social networks for the sake of her daughter, despite not experiencing isolation herself:

I do have a few friends at the school, um, and I do have a couple of friends but I'm the kind of person that doesn't like to have a huge group of friends anyway, I like to just have a couple of really good friends and family. I'm very big on family. But in saying that, I haven't gone out and joined anything, like she was in kindy for a little bit and she hated it and I didn't really get the interaction with other parents there 'cause it was dropping off. But I'm thinking of taking her to a playgroup. I should be doing that. For her as well, for socialising. She has her cousins but you know, interacting with other kids and that.

Social worker Gina connected women's isolation to societal conditions:

I feel that our society isolates mothers. One of the women I've seen recently is Balinese and she was talking about how isolated she felt because where she comes from there are aunties and her mother. The whole village raises the child. There's so much less pressure on a woman over there when they have a baby they are absorbed into the community. Here it's individualised.

Gina articulated the societal isolation of mothers who find themselves surrounded by people, yet experience mothering alone. Paris and Dubus (2005) argue that loneliness and isolation for mothers is far more common now than 50 years ago for a range of reasons, including women living far away from close family, women returning quickly to employment (Arendell, 2000; Paris & Dubus, 2005) and brief paternal leave timeframes.

A critical feminist view of isolation in motherhood makes connections between the isolation of mothers and tactics of oppression, silencing and controlling women (Diquinzio & Driver, 2001; Fraser, 1989). For example, many mothers no longer have a network of 'knowledgeable women' on which to rely during pregnancy, birth and motherhood. Instead, society has adopted what Drentea and Moren-Cross (2005) refer

to as 'scientific mothering', whereby expert knowledge has shifted from sisters, mothers, midwives and grandmothers to experts such as doctors, hospitals and authors.

5.5 Relationships as Triggers

We fought a lot when she was little. (Courtney)

The women spoke of relationships as a potential source of anxiety during early motherhood. Courtney and Miranda noted significant shifts in relationship tension with partners and husbands:

I think we fought a lot when she was little. It was all horrible. I feel bad saying that because it's not her fault. (Courtney)

My husband and I never fought before having a baby, like never. Where, during pregnancy we would have big barnies, because I can't sleep and I'm tired and all the hormones. (Miranda)

Courtney spoke of the distance she felt between herself and her husband because of his long work hours, and described her efforts to 'do it all' in an attempt to meet expectations of how a good mother and a good woman behaves:

My husband would get home 5 pm and be gone before we'd wake up. Even when he was home he would really do his own thing. I would do everything, really the fault of my own though because then I used to try and give him that break, be that mother where the husband has been working so much, all you have to do is feed and bath the baby.

Courtney's comments above reflect the devaluation of motherwork (O'Reilly, 2010) women experience as they mother within the oppressive and disempowering patriarchal institution of motherhood. Courtney's view of her expected role as wife and mother, and disregard for the value of such work, can be explained by the view that 'the

cult of domesticity rationalized the belief that unpaid household labor was women's work and that women's work was not work at all' (Barker & Feiner, 2009, p. 24).

Dana took responsibility for her marriage troubles, blaming her inability to manage her emotions as the cause:

Our marriage was not great. I was angry all the time. I was at the kids, I was just this close to the edge all of the time, I couldn't really manage my emotions.

Simone identified elements of domestic violence that became more pronounced once her children were born:

My partner has a drinking problem, he's drinking 12 beers a night at the moment, going out on the weekends at the age of 41 and getting obliterated which really doesn't help matters. The relationship is very controlling. I haven't always seen it. I haven't always noticed it. Money, he's always earned his money, spent his money, kept his money, paid the bills, paid the mortgage and I coped on my baby bonus, um, and I thought that was fine ... I thought it was his money. I never considered it was ours. I look back now and it's taken me a long time to realise he's isolated me from everybody. All these things were happening in the background.

Domestic violence adds significant complexity to the experience of motherhood. For Simone, the financial abuse, control and isolation she experienced in her relationship had practical and psychological consequences for her mothering experience. Kelly (1994, p. 52) contends that:

Domestic violence is an everyday reality which affects women's experience of motherhood. It can have profound and far-reaching effects on women's feelings and behaviour towards their children, as well as on their sense of identity as mothers and as women.

Researcher Lapierre (2010) argues that domestic violence affects women by increased responsibilities for their children and prompting a loss of control over their mothering. In his qualitative study of women's mothering through domestic violence, Lapierre's participants spoke of the way abusive partners would use mothering as a target for violence and control. Women reported miscarriages and abortions as consequences of abuse and identified pregnancy as a choice they were unable to make in the context of that abuse (Lapierre, 2010). Lapierre also found that mother-blaming was used by abusive men to attack and control women. Men would blame the abuse and violence, and the children's exposure to it, on women, labelling them 'bad mothers'. Men's domination and control of women is more profound for mothers, as it takes place within motherhood discourses that view women as responsible for their children's safety and happiness, regardless of the barriers that exist for abused women to meet these expectations. As Mullender and colleagues (2002, p. 1,447) assert, 'It is not an accident that abusive men attack women's abilities to mother, they know that this represents a source of positive identity, the thing above all else that abused women try to preserve, and also that it is an area of vulnerability'.

5.6 Lack of Support and Missed Opportunities

Where were you? Why couldn't you be there for me when you're there for other people? (Courtney)

The women spoke of having limited support and how this influenced their experience of motherhood. Courtney described the lack of support she received from family and friends and how this differed from her expectations:

I haven't had a lot of support. I don't blame my friends but my family I definitely frown upon. Especially the grandmothers, that they weren't involved and still aren't involved. I'm one of five and my mum is busy with my siblings.

They don't visit us at all. I went a whole year without a visit from my own mother. And then my husband's mother doesn't visit, although she comments that she doesn't see us enough. It draws on the pain, um, even if my sisters mention that they've been hanging out with my mum it brings back that pain of well when I was going through all of this, where was she? Where were you? Why couldn't you be there for me when you're there for other people? I just feel so much anger, because you have this expectation when you're pregnant that everyone's going to be popping over and visiting and I feel like I really deserved the visitors. What's stopping you? I'm still angry.

Other woman felt unsupported by the practitioners upon whom they were relying for advice and care. Sophie noted feeling misunderstood by her midwife:

I didn't get any support really from the hospital. It was, like she [midwife] came and sat with me and had a chat with me and tried to distract me, um, but I wanted to talk about my snowballing thoughts like how I was thinking about this and this and this and this.

Sophie's story is one of asking for help, but feeling misunderstood. In a missed opportunity for intervention, the midwife may not have recognised the anxiety behind Sophie's behaviour, or may not have known how best to respond. Rebecca had a similar experience when she approached her GP about her high EPDS score:

I was taking him to child health for the regular check-ups, however often you do that and then it got to the stage where having that one appointment during the day was just too hard and so I rang them and said I'm just really not coping and so they came out and, um, she did the screening criteria [EPDS] and so I screened in for that. So, I went and saw my GP and she, she sort of fobbed it off,

like in that she said 'It's just sleep deprivation' and it could have been that as well cause I was up all night.

When asked about practitioners recognising anxiety, Carmel and Miranda expressed their view that their perinatal anxiety had been overlooked:

I went back to the GP and I was in tears. I'm pretty sure I actually said 'I don't even want him'. I was so tired, I'd barely slept for two weeks, my parents had gone overseas, so we had no support. So, I was just ... I took her by surprise really. She was quite shocked. She just said 'Okay' and asked me when I was working next and if I needed a medical certificate and I said no. Now that I look back I probably would have said no don't worry, I'm here for him. I did ask for a referral for Ellen Barron [residential sleep centre] and she said 'What is that?' So, I rang Ellen Barron and they said no you need to go to a child health nurse and I just said 'Oh whatever' and hung up, it was just too hard. Don't worry about it. When I didn't get it [help] I did just retreat. I feel, and I'm in the medical profession, but I feel let down by a lot of the medical professionals in our experience to be honest. (Carmel)

I remember getting in the car one day after going to child health and crying and crying and crying and crying. Because I had been back to them three times and they still wouldn't help me. I sobbed and sobbed and sobbed and broke my heart in the car because no one would help. (Simone)

Miranda's experience reveals similar missed opportunities for gaining support:

Zalia: Did they screen you for perinatal mental health?

Miranda: Yeah, they did it once. They did it for Chloe. I don't think they've even done it for this [pregnancy]. I think as soon as they find out that you're a

social worker they just don't really go there with a lot of that. And I didn't think they did it well. It was interesting going through it with Chloe and even with the second one and seeing how many gaps there are, so, for me, I felt ... with Chloe I never had the same midwife once in that whole time. But going to the midwife, it wasn't like I was ever given that opportunity. They were like 'How are you going?', but it was more like a medically how are you going and not really ... and you see the waiting room as well so you know you don't really have an opportunity to go 'Well, actually emotionally this is really difficult and I'm freaking out about becoming a parent'. I didn't have any experience with kids. I didn't know how to change a nappy, I had to ask the midwife when she was born ... like, 'I don't know how to change a nappy'. So, it was an absolutely terrifying thing. And I never had that opportunity to talk about it. It's really just a pity that ... it would be nice to ... and I mean, I know that I could go to other people to talk anyway, I'm aware of that. But knowing that that's not everyone's experience and if you're trying to get help from somewhere else and things like that. And they gave me the postnatal depression stuff and said 'Oh, you know, it'll probably be more your husband that will notice that kind of stuff'. But, then, I'm the one going to the antenatal appointments, he's not. So, even if I give that (information) to him he's not going to really know what to do with it or that kind of stuff. So, I felt like that was a bit poorly done, personally. Yeah, I'll give it to him but he's really not going to know what to do.

Miranda felt that her occupation as a social worker was a barrier to being asked about her emotional wellbeing during pregnancy, and that she was not given an opportunity to speak to midwives about her psychological wellbeing. Miranda's experience raises practice concerns, as midwives play a pivotal role in face-to-face care

for women during pregnancy (Schmied, Homer, Kemp, Thomas, Fowler, & Kruske, 2008) and are often responsible for mental health screening.

Dana described a lack of support from the child health nurse that left her feeling criticised and distressed:

So then, we'd seen the horrible child health nurse, it was the same one we had for our mother's group and I meant to make a complaint about it actually. I should have made a complaint. She told me I wasn't trying hard enough. And I, I thought 'I'm actually here because I know that there's something wrong', like I've come here and I've read the books, I've already been a lot through this with one kid. I've done the thing where I don't give him any new foods. And I'm like, he's not a normal kid, he has food [allergy] stuff. Like, he needs more help. And she was like 'Come back in a month' and I was like 'I've already done this' and she then she's like 'You just need to try harder' and I left there in tears.

Dana's experience of asking for help from the child health nurse can be viewed as situated within the motherhood institution that requires her to know the needs of her child and meet them without outside guidance or support. When she was criticised, Dana's role as a mother, and therefore her identity, was being challenged, resulting in feelings of frustration, failure and distress.

When speaking about psychological support, Louise described losing trust in her psychologist and withdrawing as a result:

Zalia: Did you feel that they gave you counselling that was specifically around perinatal mental health?

Louise: Yeah, yes. Cause she has that on her sign as well. She was South African and she was really nice but there were a couple of times that I tried to

ring her to say I think I need to go on medication and I never got called back and it lost my trust in her.

Louise's story demonstrates a missed opportunity for therapeutic support and indicates the fragility of women's engagement with mental health services. In a similar story, Sophie explained her withdrawal from psychology input:

I saw some bloke who just had no idea. I was stressed the whole time while I was there that I was wasting time there that I could be doing something else. So, it caused me more anxiety being there. I never went back and never spoke to someone again. They were like 'He's really good, he's got children of his own'. I went there thinking he would give me a couple of techniques while I was there to deal with it, I didn't care about what had caused it or where it came from or what I had done for the last 20 years. I wanted to know what to do in the middle of an attack to know what to do when I wanted to call an ambulance.

Tanya's experience of mental health care through her hospital antenatal clinic involved a similar feeling of misunderstanding and, again, missed opportunities for therapeutic support. Tanya compared this experience against with her positive engagement with external support service Headspace, a nationwide early intervention mental health service for teenagers and young adults (Headspace, 2017):

I think, I think they [hospital] asked about it [anxiety] and I did try and see if there was any help there and they got me to see a psychologist and a social worker and maybe a psychiatrist. I saw the social worker a couple of times and the psychologist and psychiatrist once. That was nowhere near as helpful as Headspace though. I think it was more businesslike, in that Headspace was personal, they worked on it case by case, person by person. Whereas the hospital, they must see heaps of people with similar situations and it's not an

ongoing thing. It's basically just to make sure that you're safe, safe to have the baby and whatnot. It's not really to make sure that you're okay.

Tanya identified the value of the holistic care Headspace offered and noted a stark contrast between this and the support available through the hospital antenatal clinic. Alarming, Tanya felt that the mental health care provided by the antenatal clinic social worker, psychologist and psychiatrist was only to assess her mothering ability, not to support her with her anxiety. Tanya's experience highlights the effects of stigma for women with mental health issues, and shows how the good mother ideology is incompatible with mental illness.

Midwife Maria explained missed opportunities for therapeutic intervention as early discharge of women from hospital and women's post-birth exhaustion and distraction:

At Caboolture [hospital] for example, we have a good liaison with the mental health unit, we can get both social work or a psychologist to come and talk to a woman whilst they're still hospitalised. If we can get them in there within the timeframes, because remember women are going home from hospital so much sooner the length of stay is about 1.6 days these days. It's just, it's scary.

Particularly for first-time mums when you cannot get all the education in during that timeframe whilst they're still able to open their eyes up to look at you and take it in.

5.7 Financial Stress

There's nothing left for you. (Simone)

Financial stress contributed women's experience of anxiety, with Courtney explaining that she saw money as a deciding factor in terms of the time should would be able to spend with her new baby:

I'm working full time in the lead up to this baby, which is good. It's buying me more time with this baby as I'll have full-time entitlements rather than part time. It'll mean more money.

Courtney's experience illustrates the concept of gendered time. Stephens (1999) argues that women's time is earned, bought or stolen, and Courtney's decision to work longer so that she could spend time with her child would be considered time earned through the planning and renegotiating of Courtney's life. Feminist sociologist Terry Arendell (2000), p. 1,199) explores this notion further, arguing that 'mothers actively and continuously strategize the handling of family life and employment'.

Simone described the effect of financial stress on her ability to provide for herself and her children. Tellingly, Simone adopted an intensive mothering approach, sacrificing her own needs for the sake of her children:

That's just how it was. I was buying nappies when I was at uni, going on placement where I was working but wasn't earning so I was having to pay the daycare fees and basically pay for everything out of my child allowance. And when your baby bonus goes and you're trying to do it off your family allowance there's nothing left for you. Your self-esteem drops. You can't go out and buy clothes, you look like crap all the time ... but that's okay because you're with the baby all the time [sarcastically] and that's who you are. I couldn't afford to have any fun, I couldn't afford to go out anywhere, had no clothes, didn't feel good about myself.

Social worker Gina spoke about how finances can shape relationship dynamics: And another big source of anxiety is finances. I think that finances seem to be the biggest creator of intermarital, interrelationship conflict, um, that can leave a woman feeling inadequate and not adding to the household finances at the same

time as being pregnant or maybe raising other children as well. So, I think financial stress is also a factor.

This inadequacy Gina mentioned can be linked to the expectations of intensive mothering, where women must mother in a manner that is ‘financially expensive’ (Hays, 1996, p. 15). Coontz (2007, p. 12) supports this argument, contending that ‘today’s mothers’ emotional absorption in children and monetary outlay on their behalf are not merely high, but may be historically unprecedented’. Good mothers must therefore be good consumers to be accepted within a commercialised society where they ‘demonstrate their fitness for motherhood by amply providing for their baby in selfless ways’ (Kehily, 2014, p. 233). The consumerist pressures of intensive mothers are often out of reach, because when women become mothers, they are rendered dependent on husbands or the state for financial support, and are thus in a position where meeting the expectations of intensive, and therefore ‘good’, mothering is difficult to achieve.

5.7.1 Work.

I couldn't believe my year was over. (Carmel)

The women spoke of returning to paid employment as an anxiety-provoking prospect:

I needed to go back to work and I didn't want to. I didn't want to come back only because I was worried about leaving her. (Courtney)

Work was a trigger for me. I would get very stressed about going even though it was a late shift and I wasn't leaving my little girl for too long. She was at her nanna's house and I trust my mum with my life. I know she would look after her exactly as I would, but I don't know, going to work was a big trigger. (Sophie)

I went back [work] at 12 months. I started crying about six months before I had to go back to work, saying to Todd ‘I don’t want to go back, I don’t want to leave him’. The week leading up I couldn’t believe my year was over. (Carmel)

Courtney, Sophie and Carmel described anxiety caused by leaving their children in the care of others. This separation anxiety can be understood as an overwhelming sense of responsibility in the context of intensive mothering discourse, which requires women to reduce their paid work to provide more care for their children (Gunderson & Barrett, 2015). As Hays (1996, p. 8) posits, intensive mothering expects that ‘children absolutely require consistent nurture by a single care provider and ... the mother is the best person for the job’, and this expectation means working mothers are viewed as failing to meet their children’s needs.

By contrast, Dana felt pressure to return to paid employment:

I think up here is a lot easier. Because in the big city there’s pressure to say you’re going to go back to work and you’re going to be the director of a company.

Dana felt that the Sunshine Coast was a less competitive and pressured environment for mothers, as they did not experience the same sense that they had to return to paid employment. This aligns with research by Baxter (2008), who found that Australian women returned to work sooner than they would have liked because they feared the stalling of their careers, or being replaced in their roles.

Courtney expressed her envy of other mothers who did not return to paid employment:

When I had my year off I thought this is like a holiday, I felt like I had a year-long holiday. Then I started to frown upon mothers who don’t work when they’re meant to. Like women who have lots of babies and just get the benefit

and that sort of thing. Like then I started to feel like ‘Your whole life’s been a ride’, like young mums that become a mum and then never eventuate back into the workforce.

Courtney’s view is grounded in the notion of mothering as an unskilled caring role. As Hays (1996, p. 138) outlines, ‘in short, the world presents, and mothers experience, the image of the lazy, mindless, dull housewife—and no mother wants to be included in that image’.

5.7.2 Home environment.

You have that picture of what mums are supposed to do. (Tanya)

The women’s home environments were identified as a source of anxiety:

We were just finishing off major renos, which probably added to the anxiety, and Bruce had to go back to work really quite soon. I had Harry at home and he was two and really it just started snowballing. People would come over and that would create more anxiety for me. I’m not normally a house [proud] person but I’d be like, up at night just cleaning because I knew people were coming over the next day. And even for the first few times that child health came out they were like ‘You’re doing brilliantly’ because my house was spotless and you know, because I was so anxious that I had done an all-nighter. (Rebecca)

Rebecca’s experience represents the expectation that good mothers must also be good housewives. Interestingly, Rebecca made a connection between the midwives thinking she was coping well and the cleanliness of her home. Simone had similar feelings of stress and guilt associated with her home environment:

We moved into the most horrendous house I have ever seen. It was dire. Um, cockroaches in the cupboards. I found a mouse twice in the house. It was dirty, filthy. I had this little girl there playing on the floor, it was just disgusting. I

couldn't let her outside, it was dirty and everything was broken. We had all our furniture crammed in, there was no room for her to play. She was running around the house and I was just screaming 'Don't go there', 'Don't touch'. We were supposed to be there for six months but I had a unit we couldn't sell so we couldn't build for about a year and a half. We were there for two years in the end. I wasn't prepared, you want your nice room and your nice cupboards and it wasn't. He was crammed into the spare room with all my uni stuff, the house was just so, so small, it was dreadful and I just felt so guilty.

Tanya also felt pressure to live in a home environment that matched her understanding of what a good mother was:

There's also the anxiety about keeping the house, keeping on top of the house work. Because you have that picture of what mums are supposed to do. How mums are supposed to behave and what they're supposed to be capable of.

This pressure to manage domestic labour is also bound to good motherhood ideology through the continued gendering of paid and unpaid domestic work (Moras, 2017). In her study on the gendered nature of domestic work, Moras (2017, p. 62) found that stay-at-home mothers were particularly susceptible to feelings of guilt and responsibility, 'as they were more likely to feel as though they were not holding up "their end of the bargain"'. When Tanya conjured the image of what mothers should do, she identified what feminist Betty Friedan (1963, p. 31) named the 'the happy housewife heroine' idea of a good woman.

5.8 Conclusion

In this chapter, I have shown that for this group of mothers, individual risk factors and triggers for perinatal anxiety were intrinsically connected to broader societal ideology and the gendered experience of motherhood.

The women and practitioners spoke of the centrality of birthing to the experience of motherhood. The women described birthing as a pivotal moment in their transition to motherhood, and revealed their disappointment, fear, shame and distress when their birthing experience deviated from expectation and became medicalised. Birthing, with its ideological links to naturalness and selflessness, holds women to a strict moral code that promotes natural birth as the superior act. The women whose births had significant medical input felt a sense of failure and questioned the naturalness and ability of their bodies, perhaps caused by the illusion of choice and control. These experiences connected with the perspectives of the practitioners, who described birthing as a fear-laden time when women lose control and are particularly vulnerable.

The women also described the effects of an irritable baby on their experience of mothering. Practical issues of feeding and sleep were sources of physical and psychological exhaustion and frustration. Examined through a critical feminist lens, these narratives of women mothering their irritable child could be understood as experiences of guilt and failure connected to good mother ideology. The women's experiences were strongly influenced by 'good' and 'intensive' motherhood ideology. Breastfeeding and 'optimal' nourishment of their child was a significant source of anxiety for these mothers, who were acutely aware and fearful of their unintentional deviation from the expectations of how good mothers feed their children. Difficulties in getting their infant to sleep affected the women's physical wellbeing, psychological health and self-image as mothers. Like feeding, sleep was considered more than simply a practical motherhood skill, instead representing a benchmark of mothering success that the women felt they could not achieve. The practitioners in my study also recognised the role of sleep and feeding on mothers' anxiety, speaking of the unreal and unmet expectations that society placed on women to instinctively resolve such issues.

The women also had medical triggers for perinatal anxiety, particularly in terms of their child's health and development. Women were affected not only by medical issues that arose, but also by a fear of such issues occurring in the future. The women's stories offered insight into the stigma and blame felt by mothers whose children did not meet the normative expectations of healthy and happy offspring. For two of the women in my study, pregnancy loss contributed to their experience of anxiety, and is again linked to a natural discourse of motherhood where pregnancy loss represents the woman's failure to do what her body was designed to do.

Isolation was present in the women's experiences, even when they could identify available, supportive people in their lives. Motherhood as an isolating experience speaks to the subtle oppression and silencing of women. The emergence of scientific mothering, and shifts in the structure of family units, has individualised motherhood and redirected women to medical 'experts' for guidance and support.

Intimate relationships with husbands or partners were described as a source of tension. The women noted a shift in the dynamics of their intimate relationships and took responsibility for these changes, attributing them to hormones, sleep deprivation and emotional instability. Changing roles from working woman to mother and housewife was also raised, emphasising the devaluing of motherwork and sense of responsibility women feel to 'pull their weight' as wives and mothers. For one woman in my study, domestic violence in her relationship influenced her sense of self as a woman and mother, affecting the practical and psychological experience of motherhood.

The women raised lack of support as a significant trigger for their perinatal anxiety. The women's stories, and the practitioners' perspectives, revealed missed opportunities for meaningful support of mothers with anxiety. The women divulged feeling unsupported by family, friends and practitioners. They had windows of

opportunity when they sought help during a moment of desperation, only to have their concern overlooked, minimised or misunderstood by health practitioners. Once this occurred, the women spoke of ‘retreating’ and ‘never asking again’, thus closing the window of opportunity and showing the fragility of mothers’ engagement with support for their anxiety. The women noted that health professionals were purely on the women’s physical health or their child’s wellbeing, which acted as a barrier to raising concerns about psychological wellbeing.

Financial stress was a source of anxiety for the women, who described ‘buying time’ to be stay-at-home mothers and struggling to meet their child’s material needs. These experiences are shaped by intensive mothering discourse that connects good mother to good consumer and measures women’s success as mothers by their selfless provision of all that their child needs and wants. Returning to paid work was another anxiety-provoking period experienced within intensive mothering discourse. The women felt fear and distress when they left their child to return to work, implying the intensive mothering ideals that view the mother as the best person for the job of caring for her child.

Lastly, anxiety about the home environment and pressure to perform the role of the ‘happy housewife’ featured in the experiences of the women in my study, who felt responsible for balancing the all-encompassing role of mother with the equally value-laden role of housewife. If they did not meet these expectations, they suffered profound guilt and internal and external judgement for their ability to master motherwork and housework without fault.

This chapter has considered perinatal anxiety risks and triggers through a critical feminist lens, uncovering the broader societal influences on women’s experiences and practitioners’ perspectives. Dominant motherhood discourses can be found woven

through each of the triggers and risks that the women raised, exacerbating, and perhaps even creating, perinatal anxiety for women.

In the next chapter, 'Mental Health Literacy', I explore the perinatal anxiety knowledge held by the women and practitioners and identify poor psychological literacy as a significant factor in the experience of perinatal anxiety.

Chapter 6: Mental Health Literacy

In this chapter, I discuss the key theme of ‘Mental Health Literacy’ and argue that how women experience perinatal anxiety can be influenced by gaps in knowledge. Mental health literacy comprises ‘recognition (symptom or illness recognition), knowledge (about sources of information, risk factors, causes, self-help and professional help), and attitudes (about mental illness, sufferers, and help-seeking)’ (Ashfield, Macdonald, Francis, & Smith, 2017, p. 27). Mental health literacy informs societal perceptions of mental health issues (Jorm, 2015), and I identified significant gaps in this understanding when interviewing both the women and the practitioners.

6.1 When It’s Not Depression

They say depression but I’ve never had depression. It’s not depression to me.

(Louise)

The women’s expressed understanding about perinatal anxiety as a mental health condition was surprisingly minimal given that they acknowledged experiencing it. During the interviews, the women were not able to easily articulate mental health literacy—this is a concerning finding, as the level of mental health literacy among women is considered a crucial factor for early recognition and appropriate support (Sealy, Fraser, Simpson, Evans, & Hartford, 2009). The women I interviewed spoke retrospectively about their experience of perinatal anxiety, having only become aware of the phenomenon months, or even years, later. The women’s level of mental health literacy may explain their late diagnosis or misdiagnosis of perinatal anxiety (Ashfield et al., 2017). As the following quotations indicate, the women’s experiences of perinatal anxiety were difficult to identify, understand and articulate:

I guess I've always had a touch of anxiety but I didn't know how bad it was. Like, I could have gone my whole life without, you know, realising what it was. I thought I was fine. And you know what? Most people, most of my friends thought I was okay because I was getting everything done, right? Kids are fed, washing's done, house is relatively clean, I'm working. You know. It's all happening. You're not sitting in a corner saying 'I can't do anything'. You're actually doing everything. (Dana)

I'm a bit of a perfectionist, I like to be organised so I'm probably ... so I would say no I don't have anxiety but my husband would say 'Oh yes you do!' (Carmel)

Sophie described how she initially viewed her perinatal anxiety as stress:

At that time, I would say 'I get stressed'. I would never have said 'I get anxiety'.

Sophie also spoke about the difficulty she had recognising her anxiety while she was in the midst of it:

I thought I did alright but even now I say to my husband that I want a third baby and he's like 'No I don't really want one' and I ask why and he said 'I just don't. I just don't know if we can do the whole pregnancy, you found it really hard and it's put a lot of strain on the family'. I was like 'Was I that bad? Was I really that bad?' So, he obviously recognised a little bit more than I did.

For Sophie, a diagnosis of perinatal anxiety was a relief:

I felt like I wasn't just a looney tune, that there's a reason for me to feel this way especially because at that point I hadn't realised that I had anxiety. I didn't know that.

Psychologist Lucinda identified late diagnosis as a significant concern for women with perinatal anxiety:

There are a lot who come here when their children are two or three and just say that they weren't picked up. So, then they've lived with that anxiety for a year or two, but so has their baby. Then it can affect the attachment and their enjoyment.

Lucinda's perspective, and the women's experiences, speaks to the concerns held by researchers of perinatal mental illness such as Matthey (2003), who question the effectiveness of screening tools for identifying perinatal anxiety. Women with perinatal anxiety have been found to score significantly lower on the EPDS than those with depressive symptoms (Muzik, Klier, & Rosenblum, 2000), and Matthey has raised the issue of women who are overlooked as a result. Matthey argues that despite around half of women with an anxiety disorder having no comorbid depression (Andrews, Hall, Teeson, & Henderson, 1999), the screening tools and diagnostic interviewing used by practitioners are designed largely to recognise depressive disorders. This creates a significant gap in the care for women such as Dana and Sophie, who endured lengthy periods of perinatal anxiety without any recognition, intervention or support.

The women's stories reveal significant gaps in their mental health literacy, with most having only fragmented clinical knowledge about anxiety:

Louise: They say it's sort of a chemical imbalance in your brain. [Mum] said to me it could even be hereditary, I mean I don't know. I don't know the scientific stuff behind it. There's no real, what do you call it, mental issues in any of my family so yeah.

Zalia: Have they [psychologists] explained the symptoms and why it happens? Have they talked much about that?

Louise: Yeah, the second one did. The first one didn't, because I don't think he was ... he was a male ... and I don't think he was a postnatal you know. But the second one, cause she ... she had gone through it herself when she was really young ... so, and she was telling me as well that I should eat a lot more starch things as well like potatoes and pasta.

Zalia: Do you know much about anxiety symptoms and strategies?

Sophie: No, not really.

Louise, Tanya and Sophie spoke of antenatal education as overlooking the psychological challenges of mothering:

Zalia: Did you get much information about the psychological side of having a baby?

Louise: I did go to two classes (antenatal) but there was nothing about the mental side when I went, but yeah, I have no idea ... I think the first time as well, because you don't know what you're doing. And the first time as well, your body is going through the first time of all the hormones that happen when you give birth and afterwards. I do remember being told about having the baby blues which lasts for a day or two. That's all I was told about.

I think it was mainly focused on childbirth. I can't remember there being anything about after the child was born. So, after she was born I just remember feeling like 'How can I, someone who is not qualified for the job be trusted to help this child develop'. How is there no education on this? It's the most important major thing, it's a job that you're not qualified to do. (Tanya)

We did like birth class and it looks at looking after your baby straight after and breastfeeding and all of that so it [anxiety] could have been included as a topic

in that. It could have just been a minute long, just acknowledging it and that if you feel this way speak to your midwife, speak up. Because I sort of thought 'I'm day two I don't have postnatal depression already, I didn't really know what it was' (Sophie)

Many of the women expressed confusion about the symptoms of perinatal anxiety, as they felt that their symptoms did not 'fit' within an experience of depression. The women identified the differences between their experience of anxiety and their perceptions of depression:

I think with the postnatal depression it's like 'I don't love my baby', it's that kind of thing. But with the anxiety stuff I never felt that. I loved those boys fiercely. But that's what I think is different with anxiety. It's not like you don't have any connection with your child, you are *so* connected with your child. And maybe that's why people think there's nothing wrong because they're like 'I love my baby'. (Dana)

I'm not depressed. They say depression but I've never had depression. It's not depression to me. And I know some people do, and I believe it is an illness but I've never had that. It's just been the anxiety. (Louise)

Zalia: Do you think it's very clear what the symptoms are (for perinatal anxiety?)

Miranda: No. And I think there is a difference between postnatal depression and postnatal anxiety. Like, I would say I struggled a lot with postnatal anxiety. I wouldn't say that it was depression.

Anxiety is like, you're over caring. I think it was more anxiety than postnatal depression. Because when they did the screening I had never had thoughts about

harming my children, I'd never had thoughts about harming myself. I had thoughts that 'I'm no good at this', that I was going to wreck them. I really think it was more the anxiety, like everything was an overthink and it was just too hard. (Rebecca)

Interestingly, Sophie spoke of anxiety as having less stigma than PND:

Zalia: Did you identify with the term postnatal depression?

Sophie: No, no. If people ask me what I have I would say I have postnatal anxiety. Probably more so, because of the stigma of postnatal depression too, although I guess it would be under the banner of PND I'm not sure. But I wouldn't say I had postnatal depression, it was very anxiety driven, very much.

For Louise, stigma and fear also played a significant role in her reluctance to seek support for her anxiety:

I thought ... they're going to put me on a health plan to say that I've got mental problems and they're going to medicate me and I'm not doing either of them so therefore it's not my problem. I was so scared of those two things happening, I didn't need those. Because if they told me I was sick then I wouldn't have been coping. And I was coping because I was still here. And I was still present. And I was still going along on that treadmill. And I wasn't going to fall off and I was just going to keep going.

Despite their confusion about the clinical signs of perinatal anxiety, the women described their experience as physically and psychologically debilitating:

I just remember one day just crying the whole day, I just couldn't stop crying.

And I know that you get baby blues as well but this was more than that, so yeah it was just really bad anxiety. Like, I couldn't breathe, my mouth was dry, I just

had to get out of where I was. I couldn't sit still, people couldn't talk to me, all of that sort of stuff. (Louise)

Crying, crying a lot. Fighting a lot with my husband. Probably taking people's opinion, which I've always done but probably more so, taking people's opinions or taking them really to heart and really thinking about things that people had said to me. (Carmel)

It hit me like a bus. Irrational thoughts, snowballing thoughts, really high adrenaline. I just said to my husband 'I'm not okay, I'm not okay'. I couldn't even be in the room on my own. I would just have a panic attack. It was really hard. I would say to my husband, 'I need to go back to hospital, I just want to go back to hospital, I need to go back there'. I felt that if I was there, I don't even know what I thought they would do for me, but I just wanted to go to hospital. I just thought I can't be here, I can't do this, like I can't even have the baby like I don't want the baby. I wanted to go to a mental institution that's what I kept saying. I need to go to a mental institution, I just can't do this, this is ridiculous. I was so out of control. It's not until I talk about it that I realise it was pretty bad. (Sophie)

You're kind of forward thinking everything. So, going 'Okay she's on that swing but she could fall off, she could crack her head she could end up ...', instead of just going 'She can swing and you know what if she falls off we can deal with it'. I'm a control freak as well. If I don't have daughter in my sight and controlling the situation that anxiety because of the lack of control kind of goes a bit crazy. For me it's more a physical kind of thing it's just like that shortness of breath, that panic pretty much. Your head's running a million miles per hour and mine's probably more that forward thinking, thinking of all these scenarios

that possibly could happen. What would I do? Where would I go from there? And I generally get quite sweaty. I'm pretty exhausted after an anxiety attack and kind of just really don't want to do stuff. So, you also feel quite silly. You know that the people you're leaving your kid with are going to care for them and that's why you leave them there but you can't help. Like even here [interview] to be honest, I'd just rather be with her. Not that I necessarily want her company because she drives me fricking bonkers, but more because I'm like 'I don't have control, I don't know what's going on'. So even if I'm at work the whole time I just want to be with her and it's not just that I want to hang out with her it's that I want that control. (Miranda)

I had the physical symptoms. I would constantly be in this highly aroused state, like constantly on edge and increased heart rate. I lost an incredible amount of weight, um, ridiculous amounts of weight. I was just a stick, I felt gaunt. When I would wake up to feed him my mind was just racing and I couldn't go back to sleep. I still experience that, not that frequently, but even now when there's big stuff going on, or big change, I will wake up with this racing heart and then I'll start thinking 'Did I do the right thing? Was the move the right thing? Have we wrecked the kids?' Over the top stuff that I will process all night long and I will feel awful. I was so anxious. I was an absolute mess, I thought I was going to go crazy. Like it was really, really horrible. (Rebecca)

I'm organised. I'm actually a bit over organised, yeah. I have to plan things. Sometimes it's too much, like I'm overthinking things too much ... like I can't switch off. When you're thinking into things way too much. I think into the future a lot. (Courtney)

Psychologist Lucinda described the types of anxiety she sees on a regular basis in her clinic:

It's generalised [anxiety] I would say, and the only other thing that has come up a lot is intrusive thoughts. So, that I might hurt the baby, or I might sexually abuse the baby, I might drop the baby, so those intrusive thoughts are there a lot. It's often associated with [obsessive compulsive] type of behaviours. It's really learning about how to manage those thoughts and it doesn't mean you're going to go out and hurt the baby. But all of that is very anxiety-provoking, I mean if you think that every time you walk past a knife you might do something. It's very hard (to admit). It's terrifying. It's awful. We see that quite a bit.

Social worker Gina spoke of needing to notice anxiety clues in women's behaviour:

They use other words. I think 'anxiety', it seems to be a buzz word today for what was always seen as 'nerves' or being a 'worrier'. So, I would generally start off with 'Would you tend to worry about things' or they might identify just through their speech, I find fast speech, if they speak quickly, that is a good identifier for anxiety.

Gina noted the difficulty in recognising anxiety and related it to societal norms: The thing is that I don't think they do present as 'flat' if they're anxious. I think if they present well that starts raising flags for me in their wanting to be a perfectionist. Perfectionist behaviour says to me that there's anxiety there. Is it easier to identify depressed women than it is to identify anxious women? Yes, absolutely. In some ways, all of the behaviours that are a cover for anxiety, the perfectionism and being a high achiever, having a clean house, you know even joking and saying they're a bit OCD [obsessive compulsive disorder], they are

all rewarded in society. They work hard, it's seen as a positive rather than 'Hey where's the self-care here?' It's hiding the panic underneath, it's about knowing what to look for.

Gina raised an important point about the societal value placed on women's behaviour. Depressive symptoms such as low motivation, social withdrawal, excessive sleep, inability to cope and pervasive feelings of despair (Horowitz & Goodman, 2004) are not conducive with the expectations of good mothers. However, anxiety symptoms result in mothers who are hyper-vigilant, fearful of failure, perfectionistic, self-sacrificing and excessively preoccupied with their child's welfare: all behaviours that represent the intensive mothering that good mother ideology demands. These expectations of how motherhood should look and feel could directly affect women's mental health literacy and ability to recognise their experience as something other than simply trying to achieve the good mother image. As Dana noted, if women love their infant, there is a sense that they must still be coping and able to persevere with mothering without additional support. This ideological perception could explain why women take individual responsibility for their perinatal anxiety symptoms, seeing them as signs that they are not achieving good mothering rather than indicators that they need support or treatment. For Simone, this perception of 'coping' prevented her from accessing support when her perinatal anxiety was at its worst:

You've got the people who are flat and then you've got the people who are dressed, who are in there saying 'I need help' and that's what happened to me with child health. [It was] that I looked okay, that I was fine. And they actually said that. And I was not fine and I said that. I reckon that I was probably asking 20 times for help and I never got it. I asked three separate GPs, Ellen Barren on the floor in tears begging them to let me in but they had no room. I was on the

phone constantly saying 'Please help me, help'. They were like, 'You're doing fine' and I kept saying 'I am not doing fine'. I knew I needed some help and I was asking and asking and I didn't get it.

Simone's experience of being unable to access help when she needed it can be explained by women's care being managed according to a purely medical model. As social worker Gina explained, the medical model within which women mother shapes the care with which they are treated, and feel worthy of:

I think in the medical model, it's almost neoliberal I guess, it's permeated down that whole onus being on the individual to succeed and to manage their own lives and at a time when they are most vulnerable and need that support it's not always there. There's a lot of blaming the victim. I think it's not taking into account what's brought them to that stage.

As I have shown here, women's mental health literacy was fragmented, which resulted in feelings of confusion, shame, frustration and isolation. A critical feminist view of the knowledge gap the women identified could be connected to a form of oppression and silencing. For the women I interviewed, perinatal anxiety represented what Betty Friedan (1963) termed 'the problem that has no name'; a reality with which other women in similar situations could identify, but one that had no name or explanation and that therefore held no space in the public realm. Although Friedan did not refer to perinatal anxiety itself as a source of women's oppression, she did apply the concept of the feminist mystique as a blinding veil that placated women into accepting their lived experiences as 'good enough'. By keeping women in the dark about the meaning of their lived experiences and silencing those who raise issue with their role as mother, this veil of mystique can be characterised as a factor in the limited mental health literacy of the women in my study.

6.1.1 Practitioner mental health literacy. It is not just the mental health literacy of mothers themselves that influences the perinatal anxiety experience. As the women interviewed described, practitioners play an integral role in recognising perinatal anxiety and connecting women with treatment and support. Despite this important role in the care of mothers with perinatal anxiety, gaps in the mental health literacy of health practitioners has been documented as a cause for concern (Noonan, Galvin, Doody, & Jomeen, 2017).

Research has found that although midwives undertake perinatal mental health screening, they are not confident about how to respond to a disclosed history of mental illness (Ross-Davie, Elliot, Sarkar, & Green, 2006, as cited in Noonan, Galvin, Doody, & Jomeen, 2017) and hold concerns for how to support women experiencing psychological distress (Sanders, 2006, as cited in Noonan, Galvin, Doody, & Jomeen, 2017). Obstetricians and paediatricians have also been found to hold reservations about identifying mental illness in new mothers. There are a variety of reasons for this, including low confidence in talking to distressed women, limited clinical time and fear of alienating or further upsetting women by asking about their mental health (Tam, Newton, Dern, & Parry, 2002). Midwives' and doctors' reluctance to ask women about psychological or social difficulties (Ramsay, Richardson, Carter, Davidson, & Feder, 2002) is concerning, as these figures are often women's first, and only, source of professional support.

Midwife Maria explained her midwifery role in supporting women with perinatal mental illness, in which she felt that counselling plays an important part:

We provide quite a lot of counselling, although it's not called counselling. It's a huge part of the role. Because we're there to support them. We're there to support the women who have those tentative feelings about being pregnant and

how they're going to manage. It's part of the talk, the discharge education talk. The list of things we cover in that talk goes from their health and wellbeing, their breasts, their blood loss and so on and so forth and it covers the emotional stuff, it's quite comprehensive. And where to go for help, and if you find that you're still sad about the birth of your baby two weeks after birthing then you must see your GP, it's really important because that may be the first sign of the postnatal depression. And that may be a sign that things are not going as well as they should.

As Maria indicated, the focus of perinatal education for women continues to be on the experience of depression, rather than on informing women about the signs and symptoms of anxiety.

By contrast, social worker Gina described her therapeutic approach as having a holistic focus:

I guess I gauge it by talking to them as an individual and what works for them. Sometimes I've found that they're already seeing a psychologist so I might recommend that they either re-link or continue to see the psychologist. I talk to them about managing anxiety strategies so that would be finding out what works for them. I think that's really important. I think it's about exploring what works for them and I think each person really does know what works for them. I have noticed that the women I've worked with ... antenatally ... I think they manage better and respond better to intervention post-birth. I think they're more accepting than the ladies that I see in maternity who I haven't seen antenatally. I find that they are really highly anxious, they think 'Gee I must be bad if they're sending the social worker in'. I have found that the antenatal work really helps.

There's no way to prove that, except the smooth transition that the midwives and staff may notice, they may notice that things run a bit smoother.

Psychologist Lucinda spoke of her therapeutic approach to supporting women with perinatal anxiety:

The more antenatal ones are the women who have come to us after the birth of their first baby and want to minimise the impact for their second child. And their risk [of anxiety] is higher. So, we just do some preventative type of work and preparing them for that second baby and that's been very satisfying work.

Interestingly, Lucinda noted that the treatment for perinatal mental health is similar to that for standard depression and anxiety management:

The treatment's fairly similar really, it's the similar way that we would treat all anxiety or all depression.

This observation is notable, as the treatment does not recognise the unique challenges women face during motherhood. As the interviewed women explained, their anxiety was experienced within a very specific context of sleep deprivation, birth trauma, feeding difficulties and caring responsibilities; all of which are unique to mothering. This raises the question of what form the psychological care for mothers should take, as their mental illness is being experienced within, and arguably exacerbated by, the tall walls of the institution of motherhood, which traditional anxiety treatment methods may not acknowledge. This could be considered a barrier for women to receiving therapeutic support that views their experience within its broader social and political context.

Midwife Maria articulated the barriers midwives face in trying to share mental health knowledge with new mothers because of the practical difficulties of engagement:

The problem with that is that after the birth the women have switched off, they are not interested in hearing about what is going to happen after the birth. We have tried to introduce more stuff about postnatal anxiety but we've found out that they shut down and their partners shut down. The whole focus is getting the baby out. We have tried, and that's what makes it [perinatal mental health awareness] so hard. And I'm not sure how you get past that barrier other than women recognising that their bodies are designed to be having babies. I would like to think that over that time that it would improve but that's still a concern, that many women still can't think past the birth. It's a blur after they've had the baby because we're trying to get so much information into them.

Maria described the reluctance of some midwives to pursue further professional development to increase their mental health literacy:

Many wouldn't, and wouldn't see the need. They may recognise it [perinatal mental health risk] but they may not act on doing something about it. I'm into early intervention. There's not a lot of formal stuff out there though for this sort of thing, although increasingly it's being recognised as an area of need and, my thing has always been that I'll go and look for it (information) myself. So, whenever I've found an area where I really need to know more about it then I will go to the library or the computer so I can access research papers. But then I guess I've always had a slightly different perspective to some other midwives because of my background in education.

Obstetrician Brenda spoke of her own limited mental health literacy and how it shaped her clinical practice with women:

Zalia: How much mental health training do you have?

Brenda: Very little. Um, well the thing is we can't be experts on everything. So, I think it's good if we can have other speciality teams that we can refer to. But then, I trained years ago, so I don't know what the recent trainees have had. I doubt if they've had too much.

Zalia: Is mental health a focus of obstetrics intervention?

Brenda: No, not normally. No. I haven't seen any psychosis, um, and with regards to the anxiety and depression we just accept that people are going to have it and we have a specialist team that we can refer to. I think the perinatal mental health team look at all mental health issues not just depression.

Zalia: What sort of practitioners make up the perinatal mental health team?

Brenda: I don't know actually. I should know. But I don't.

Brenda's description indicates a siloed model of care, where practitioners operate in isolation from one another in their care of women. Evidence suggests that perinatal mental health outcomes could be improved by establishing a collaborative, multidisciplinary model of care (Halbreich, 2005). In her integrative review of perinatal mental health care research, Myers (2013) argues that women with perinatal mental health issues are at risk of dichotomised care and barriers to service engagement because of the range of health professionals with whom they engage, and the period for which they are engaged. Myers (2013) notes the need for health practitioners to form collaborative partnerships in caring for women with perinatal mental illness.

Midwife Maria echoed these concerns in her experience of working across several primary health areas:

It can be very siloed. I have seen that a lot in hospitals. I saw it in Western Australia and in Melbourne. It was incredibly siloed, and they [women] can't

move across anywhere. And they're all saying something different, so they are very confused. You really need someone to just bring it all together. And you must have someone who has the skills, the background and the experience for that who can actually intervene quickly. But of course, you know, we're looking at money here for intervention of services, that's the problem with Queensland generally. We have not been into intervention, we've been into tertiary care. So, we wait until it all falls over and then we'll 'fix' it and it's absolutely ridiculous.

6.2 Conclusion

In this chapter, I have identified mental health literacy as a significant issue for women experiencing perinatal anxiety, and for the multidisciplinary practitioners responsible for their care. I have argued here that fragmented mental health literacy for both women and practitioners may be a factor in missed opportunities for identifying perinatal anxiety and enacting timely intervention.

The women spoke of their difficulty in recognising perinatal anxiety and the confusion they felt when their experience was labelled depression. Despite recognising their perinatal anxiety to the point of participating in the study, the women struggled to articulate the signs and symptoms, risk factors or recovery options for this condition. Considering these gaps in mental health literacy through a critical feminist lens, I argue that women's lack of knowledge about perinatal anxiety acts to further silence and oppress them.

When speaking about therapeutic interventions, psychologist Lucinda described her approach to perinatal anxiety as the same as that used to manage anxiety for other client groups. This raises interesting questions about the appropriateness of therapeutic care that may not acknowledge the unique practical, social and political context of perinatal anxiety.

The practitioners spoke of their frustration in identifying and responding to perinatal anxiety. The siloed nature of service provision was raised as a barrier to meeting women's needs, and collaborative practice was articulated as an ideal yet to be achieved.

Maria's midwifery perspective revealed gaps in midwives' knowledge and confidence in terms of recognising and responding to perinatal anxiety. This aligns with a recent report on mental health literacy by Ashfield et al. (2017, p. 22), who noted that 'educating mental health and human service professionals, and other relevant workforces (whose role or function has implications for the mental health of individuals) in the situational approach to mental health literacy, will be essential'.

In the next chapter, I explore the women's stories of strengths and support that have nurtured resilience, encouraged empowerment and made tangible differences to their experiences of perinatal anxiety.

Chapter 7: Strengths and Support

In this chapter, I present the theme of ‘Strengths and Support’ through its subthemes of practitioner support, social support, asking for help and medication. Support plays a key role in the mental health of new mothers, with limited support associated with increased risk of depression and anxiety (Lin, 2015; Myers, Schmied, Johnson, & Cleary, 2013). Feminist discussion on support for mothers highlights the effect of dominant neoliberal discourse that places responsibility on individuals and views mothers as solely responsible for their themselves and their children (D’Arcy et al., 2011). This individualistic ideology complicates the support offered to, and accepted by, mothers. Feminist and motherhood researcher O’Reilly (2008) argues that mothering can be an empowering experience if social and cultural change is achieved. So far, the themes I have identified highlight significant gaps in support for women, and I have contended that women’s access to, and acceptance of, support is complicated by dominant good mother discourse and the oppression mothers face. As evidenced by the quotations in this chapter, women’s experiences of asking for and receiving support can be both oppressive and liberating; these findings illuminate directions for a more empowering experience of mothering.

7.1 Practitioner Support

It’s extremely helpful if you have a doctor you see regularly who is supportive of your anxiety and believes in it. (Tanya)

Support from health practitioners featured in the women’s stories, and when describing this support, the women often identified doctors as their first point of contact. Interestingly, they suggested that not all doctors would be supportive, and that finding a GP who understood their perinatal anxiety was essential:

It's extremely helpful if you have a doctor you see regularly who is supportive of your anxiety and believes in it. (Tanya)

I had a good GP. We had a lot of anxiety around breastfeeding and things like that, so it was really good. But, again, that was, I was just really lucky that I got a good GP who could kind of go 'You know what? One, you need to get some sleep. And you need to get off Google, like, because that anxiety is really ... you're driving yourself crazy with things you don't need to. Your kid doesn't have bow legs, it's only like three months ... give it a break!' (Miranda)

Psychologists also featured prominently in the women's experiences of support. As Louise and Miranda noted, psychologist input was a learning experience and a way of 'upskilling' to manage anxiety:

I went and saw a psychologist as well. It was my first time. I found it really good because he taught me some really great breathing exercises so I used them and they've helped me through this whole time really. And I think it helps to talk about things, definitely. (Louise)

I think I was lucky because a year ... before we had Chloe I did go to that psychologist and look at anxiety and mindfulness skills and stuff like that. I think that was really quite useful in preparing for Chloe so I can use those skills. I think if I hadn't had that it would have been ... (Miranda)

For Dana, her history of seeing a psychologist helped her proactively seek support during her pregnancy:

I started seeing someone pretty early on when I was in Sydney because I was like, I'm losing my mind. I just Googled. I had been in therapy before and I was like, I'm not, I'm not doing well. I found that really helped to manage my

expectations. I think, um, like that worked for me: talking therapy. I think I just knew, I was lining myself up for after the baby too. I wanted to have someone that I knew, and I found her really great. And like, I'm seeing her next week. I don't go all the time but I still go and check in like, when this food [allergy] stuff really kicked up again.

Tanya's experience of seeing a psychologist differed to that of the other women: I saw a psychologist. Yeah it was definitely helpful, just to have an unbiased perspective. To get some perspective on it and um, some practical strategies because I suppose it was still a lot of the social anxiety at that point so I was dealing with that to try and up being more functional. It was pretty straightforward because I went to Headspace. They set me up with a psychologist and tried to help with housing so because of that service it was yeah, there was one person that looked at my case and decided what sort of services could help like the housing services and the psychologist and like a doctor.

Tanya's experience of receiving practitioner support speaks to the value of holistic care. Approaching mental illness from a holistic perspective is a growing theme in contemporary mental health practice and policy design, and sits comfortably within a social work framework of care (Khenti et al., 2015). Approaching mental health care via a holistic and collaborative framework has been linked to more positive outcomes than those gained from individual practitioner support (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006). Social work has played an important role in the redesign of mental health care through its recognition of the contextual nature of mental illness and the links it makes between disadvantage, oppression and psychological wellbeing. Mental health social workers such as Karban (2016) argue that individualised recovery ignores

the relationship between inequality and the social determinants of health. As Tanya described, Headspace's holistic approach allowed her to access support for her anxiety while addressing the contextual factors that were affecting her wellbeing.

7.1.1 Family and friends. The women referred to a network of informal support that helped them manage their experience of perinatal anxiety. Family support was particularly integral to helping to overcome the barriers of anxiety and the challenges of mothering:

I do have a lot of family support but I pretty much moved down here on my own to be closer to Mia's grandparents because I'm very close to her side of the family. (Louise)

Family support helped me. Having people to encourage me to go and to, yeah convince me that it was worth it and to go with me, um. And especially when you're finding reasons not to go and justifying it, you need someone supportive, a partner or family. Family are major like when you really can't cope, when you haven't slept all night they'll drive you home in your own car [laughs]. (Tanya)

My mum works from home so I have a lot of support from her. During the day was really bad. I'd get up in the morning and quickly shower and go to Mum's house because I couldn't be home alone. I needed someone there to help me. (Sophie)

Her grandparents are at Bribie, so we go to Bribie a lot at the weekends and they just love the kids. As soon as you get there you don't do anything, it's a really good break. (Louise)

Friends, particularly other mothers, were a source of support for the women:

Friends that are supportive, especially mum friends. I was lucky to meet Hayley [friend] because she's not afraid to admit that she's struggling. So, it's nice to have people like that. (Tanya)

I had a really good support in my friend, she works with me as well. My friend would listen. (Carmel)

I went and joined a playgroup and I met one of my really good friends there who I'm still friends with today. (Louise)

Friendship and motherhood have been explored by motherhood writers and researchers such as the sociologist Cronin (2015), who describes motherhood as a pivotal time for women's development of friendships. Cronin (2015, p. 666) argues that friendships are 'important sites for developing a sense of self or identity' and involve inclusive intimacy that forms emotional bonds and provides opportunities to exchange experiences and support.

7.1.2 Husbands and partners.

I'm very lucky to have a supportive partner. (Dana)

Husbands and partners were considered a source of both practical and psychological support:

Jessica is at her dad's once a week so that's a bit of a break. So, if I didn't have that it might be a bit of a different story but, yeah, I'm getting that break as well which is really good. (Louise)

He was amazing, sometimes I was just like 'You don't understand at all. Don't tell me to calm down. I can't calm down at all'. But he very quickly knew how to help me. (Sophie)

The women spoke of their 'luck' at having 'good' husbands and partners:

I've got a good husband. He was very supportive and he'd be saying 'You're doing good'. (Carmel)

I'm very lucky to have a supportive partner. I can imagine, as hard as it is for him, and it hasn't been all you know peachy. Because we work from home he does get it, he's with the kids, he sees a lot more of it. I think this [anxiety] also affects the partners really badly, I mean, he was just trying to hang on as well and manage me, and he was just like 'What is going on?' because I couldn't communicate effectively. I was angry. And you know, I just felt like I'm doing so much. I'm doing so much and the relationship balance is just ... so he was probably terrified to ask me anything and I needed him to know what I needed and I couldn't tell him what I needed. (Dana)

Stuart is great because he is proactive in wanting to be a better parent and wanting to get more knowledge and things like that, so it's not just 'Well this is how I'm going to do it'. I am pretty lucky that he's involved. (Miranda)

The women's thankfulness, and perhaps surprise, for the support of their husbands can be linked to the resilience of stereotypical gender norms (Ridgeway & Correll, 2004). Of concern to feminist writers is the entrenched nature of such gendered expectations, which leave women feeling lucky to receive practical or emotional support from their husbands or partners—this suggests little meaningful change from the dominant ideologies of the past (Boudet, Petesch, Turk, & Thumala, 2012).

7.1.3 Mothers' groups.

The mothers group helped. (Tanya)

A local mothers group was a source of support for Dana and Tanya:

I was very lucky because I had an amazing mothers' group and we're still, one I talk to every day still. (Dana)

The mothers' group helped. The community health program, they had little talks from people and I remember one of the last sessions where everyone, um, said something that they were struggling with since having a baby, the hardest part they had found since having a baby and that was really amazing to hear everyone's things. One lady was struggling because she'd had a baby (older mother) and she was struggling, she was so used to having her life; she did what she wanted when she wanted and she had her career and she went out at night and had dinner parties and all of a sudden she's isolated and can't do anything except look after the baby which is a shock at first especially when they're not giving that much back. I remember there a few others and everyone had a different thing that they found difficult about it and that was great. (Tanya)

The normalisation of 'real' mothering experiences was helpful for Tanya, alleviating the sense of isolation prompted by her own struggles. Tanya's experience of hearing the difficulties of other mothers can be understood as a process of breaking down the illusion of the motherhood mystique. Motherhood is experienced at an individual level, despite the ideology behind it being created and maintained at a broader societal level. Sociologists Newman and Henderson (2014) contend that when women become mothers, they take on this ideology as truth, internalising dominant expectations of good motherhood and further perpetuating this discourse. When Tanya heard other mothers confessing their deviation from good mother ideals, it planted a seed of consciousness about the truth of the mothering experience. However, this is likely just the beginning of a reconceptualisation of motherhood, rather than a revolutionary step—for as Newman and Henderson (2014, p. 487) found in their study

of intensive mothering and support groups, women's experience of support group membership often 'silenced their troubles instead of translating them into larger social issues surrounding the dominant discourse of motherhood'. Therefore, although Tanya was able to lift the edge of the veil of good motherhood, it is likely that this validation did not transform into a consciousness of how her own feelings of inadequacy were related to larger social structures.

Participant psychologist Lucinda described the benefits of her perinatal mental health groups in challenging good mother ideology and connecting women with one another to create a support network:

That's the beauty of the groups, yesterday there were seven women and none of them were enjoying (pregnancy) and they were able to say that. For them to say 'Well, this isn't all I thought it was cracked up to be' and for there to be no judgement. So, over the course of the eight weeks their moods have improved significantly. They all talk on closed Facebook sites, so when they're really anxious or having a bizarre worry they just put it up there and they all support them.

7.1.4 Residential clinics. Some of the women mentioned short-stay residential sleep clinics as a significant support. There are no residential sleep clinics on the Sunshine Coast, which meant that the women travelled to the nearest city, Brisbane, to access this support. Tanya and Rebecca described their experience at the Ellen Barron Family Centre:

The first time I went they were definitely offering help with [anxiety] too and they have the little parent's classes and a lot of those are focused on anxiety and realistic parenting which is really amazing. They said you've only got to get it right 60% or something like that for your child to grow up okay so there's some

room for error, that was extremely helpful. I feel like that should be, I wish that that was available for everyone once a year or something. It's good to have those types of places because [they] give you information on how to deal with those situations and how to help them develop and stay sane. (Tanya)

I was in there and stayed there for a week with both kids. That was amazing, it was so good. So, they just, I think it was just not having the stress of running the household, no one was coming over. We walked into a room for our meals and they were cooked and cleaned up. And I could just focus on the kids. Then, when Toby was going down to sleep, having someone there to say 'Yes, this is what you need to do, you're doing okay'. Or having someone occupy Harry whilst I was focusing on getting him to sleep. After that week, we came home and they were sleeping. It was incredible. (Rebecca)

Rebecca's experience reflects the isolated neoliberal environment within which mothers operate. As Rebecca articulated, her experience of the sleep clinic was profoundly positive: she felt the weight of individual responsibility lifted from her shoulders. Critical feminism views motherhood as situated within a narrowed family structure void of extended family support, and upheld by individualistic values and the gendered division of labour (Arriagada, 1997, as cited in Leite, 2013). Radical feminist Dorothy Smith (1987) advocated the importance of recognising and challenging women's oppression at the level of their everyday lives, where they are first silenced and oppressed, and making knowledge of women's everyday norms vital to understanding of their broader societal oppression. When Rebecca explained the relief she felt at being given meals, child minding and reassurance, she recalls the everyday lives of mothers who are expected to meet the overwhelming requirements of mother and housewife alone.

Dana chose to attend a private sleep clinic, Nurture Centre, also based in Brisbane:

I said to the psychologist, I've got to get in somewhere this kid's not sleeping, I'm going to lose my mind again. And so, she did all the paperwork for Ellen Barron and I was like, I'll try Nurture Centre as well, because you can get in there a lot quicker. We don't have anything up here (Sunshine Coast). The North West one is a private one and if you've got private health it's only 500 bucks. They were amazing. It's a lot smaller unit. There's only six babies, I think, at a time. And it's in a wing of the private hospital and yeah. It helped. It helped more in the fact that those nurses were very, like he just didn't sleep and they were like 'Look at him, he's got allergies. He's not going to sleep if he's itchy'. So, I got a lot of practical help there which wasn't all about the sleep, we did a lot of sleep stuff but they were, it's more of a holistic thing.

The holistic model of care these sleep clinics provided was of significant help to all three women. With their practical and physical needs met, alongside reassurance and guidance from staff, Tanya, Rebecca and Dana left the centres with increased confidence and reduced anxiety. Research has found that a lack of support for mothers' practical and physical needs can contribute to their poor mental health (Negron, Martin, Almog, Balbierz, & Howell, 2013), and the women indicated that these basic needs had to be met before they could shift focus from their children to their own emotional wellbeing.

7.2 Asking for Help

Sometimes it's like no one is really listening, or like we're on a different page. I feel like I'm asking and why aren't you picking up on these signs? (Courtney)

Asking for help was another theme I identified as a significant barrier for the women to seek out and access support. Women's help-seeking behaviour in the perinatal period is generally very poor, with Henshaw, Sabourin and Warning's (2013) survey research on treatment seeking behaviours finding that only 13.6% of women with perinatal depression had sought help. Married, pregnant women with no previous history of psychological issues were significantly less likely to ask for help, as were first-time mothers (Henshaw et al., 2013). Stigma is thought to play a major role in women's reluctance to seek help for mental illness during pregnancy or early motherhood, largely because women feel shame about doing this and fear that they may be considered unfit to mother their children (McCarthy & McMahon, 2008).

In my study, stigma and fear of judgement were clear deterrents to the women asking for help:

I rang child health and they started coming out to the house which was just brilliant. But then there's the guilt because clients get that service ... not I ... you know? What's wrong with me that I've got this [support]? To go from the expert to the client. (Rebecca)

It was all very hush hush, no one knew I had it [anxiety] because I didn't want people to know. I mean, I've just had my baby and she's beautiful and I don't want her? Like, you can't tell people that. (Sophie)

Rebecca's and Sophie's experiences of asking for, and accepting, help were influenced by power and stigma. Rebecca noted the invisible power imbalance that exists between client and expert and acknowledged her difficulty in becoming the client. She raised the idea that services and support are for clients, suggesting that only those who cannot cope are meant to receive such assistance. Sophie's experience indicates the thoughts and feelings good mothers are not supposed to have, since she suggested that

her perspective would be judged negatively by others. These experiences speak to the work of feminists who have explored help-seeking barriers for mothers. The failure mothers feel when asking for help (Mauthner, 1999) is linked to the internalisation of motherhood ideology (Thompson, 2001) that causes mothers to see receiving help as a sign of inadequacy and mothering/womaning failure. Feminist scholars Choi et al. (2005) connect this internalised sense of failure to discourses of femininity and motherhood that depict the ‘perfect woman’ who does not require help. Asking for help is then connected to women not coping with a role that society and, by extension, the mothers themselves, perceive as their innate purpose.

This fear of failure and not coping is also evident in Carmel’s story—she expressed her difficulty telling anyone about her anxiety and suicidal ideation:

I wouldn’t have felt safe enough at all [to say it]. I wouldn’t have even told my husband the extent of that, he would know most of it but I didn’t tell him everything, how bad I was. I just had really silly thoughts, not to the point of hurting him ... hurting myself, but not to the point of hurting him. So, I figured I’d be okay cause I still had love for him and that would keep me going. I knew I wouldn’t hurt him, even on the nights or days when we hadn’t slept all night or all day and I would just say to him ‘Just SLEEP’. I would get upset at myself for getting angry with him and we would just both cry together. But I would never have hurt him. But I could have potentially hurt myself and I wouldn’t have been able to tell you that then.

Carmel’s description of her anxiety and suicidal ideation signifies the additional challenges mothers with psychological issues face. Despite admitting that she had considered harming herself, Carmel was quick to reiterate the love she had for her child and state that she was never a threat to his safety. According to Murray and Finn (2011),

Carmel's defensive stance and desire to assure the safety of her child is linked to societal perceptions of 'bad thoughts' (either towards the infant or the mother herself) as experienced only by bad mothers. In their feminist study into mother's intrusive thoughts, Murray and Finn (2011) describe the vilification to which mothers are exposed when they have these 'bad thoughts', and the automatic labelling of mothers as bad should they not present according to expectations: healthy, happy and well adjusted.

Carmel went on to describe separation anxiety from her son as a further barrier to accepting help:

Carmel: My parents have offered to [babysit]. They are really doting grandparents. Um, they did offer many times but I felt he was my child, he's my responsibility and I didn't have him for someone else to bring him up. And I didn't want to miss out on time with him, so they would offer and my husband would offer too.

Zalia: If your husband offered to take the baby for an hour or two what would you have done?

Carmel: I would have said where are you going? I'll come too. The chiro said he's a very 'fear of missing out child' and that's me too, very much. I want to be there. Now I'm better. The first time I left him was when he was five months, I just cried when I left and I did enjoy myself during the spa treatment but as soon as it was over I just wanted to go back to him, and he was fine. But I just think 'What if he wants me and I'm not there' which is just, I'm sure that's just normal. I would have been able to ask for help if I had really needed it I think, and I would have had people there to offer it to me too.

Carmel's reluctance to share the care of her child with her husband or family aligns with the expectations of intensive mothering. In their study of mothers' social

support, Negron et al. (2013) found that women saw asking for help as a negative reflection on their capacity to look after their children. This fear of judgement and perceived criticism is reflected in Dana's experience:

I think, I used to get anxious about asking for help. And even my friends in Sydney were like 'If you need to sleep we'll come over and look after him, or we'll take Jasper out and you can have a sleep' and I never took them up on that because I still felt like then I'm failing at it, like I can't cope. And at that point I didn't even think to ask my husband to get up at night. I think there's so much pressure around that 'You should be able to do it all' like I don't know why but it didn't even occur to me until week four when I hadn't slept and I was like, I just can't. And I just expected that I would be able to do it all myself, and I put so much pressure and I was anxious and then all the sleep stuff became a focus of my anxiety.

Anxiety itself was a major barrier to Rebecca asking for, and receiving, help: I never left them with, even with my mum. With Harry I did ... but then I didn't experience that anxiety with him, just the normal anxiety. Like, I'd go off to work at night time and I'd express milk and he would drink it and I would still feel like he was going to be okay. But if that was Toby, it was just no way. I didn't go back to work until he was a year and a half and that was really the first time that Bruce got left with both of them. It's all consuming. It's that whole chicken-and-egg thing. You know, I'd think well maybe if I did put my foot down and do some self-care or called upon someone to say could they take the kids so I could have just an hour a week or whatever, I wonder if that would have made a difference, but I think I just would have been so anxious about it the whole time.

Rebecca's chicken-and-egg analogy reveals the complex interplay of anxiety and the consequences of oppressive ideology. Trapped in a circular pattern, Rebecca acknowledged her need for self-care and outside help, yet could not access it because of the intense anxiety that seeking and accepting support would lead to. Essentially, the dominant discourse of 'good' and 'intensive' mother placed Rebecca in a position of disempowerment, where the fear of admitting struggle overwhelmed her need for help.

Sophie identified lack of knowledge about available support as a barrier to asking for help:

Zalia: Would you have known where to look for that sort of support?

Sophie: No, no. I did see a lady with a car and there was a sticker on the side and it was advertising her business which was pre and postnatal depression and she hopped out of the car as I did and I said 'Do you have a business card? I don't need you now but I might need you sometime'. Because I knew I'd have another kid. But she didn't have one, so I took a photo and of course when I probably needed it I couldn't find it. So, I just muddled my way through again I suppose. You do think that too, I've had my baby I'm not okay but where do I go and who can I talk to? Like, I don't think it's their (obstetrician's) job anymore but whose job is it?

Psychologist Lucinda also described a lack of knowledge as a barrier to women accessing support:

Zalia: Do you see women antenatally?

Lucinda: Yes, we'd like to see more antenatally. We've been around for years but so many people on the Coast still don't even know that we exist. And we've tried to get the word out, absolutely, we're always trying. The more antenatal ones are the women who have come to us after the birth of their first baby and

want to minimise the impact for their second child. And their risk (of anxiety) is higher. So, we just do some preventative type of work and preparing them for that second baby and that's been very satisfying work. We've tried to advertise emotional preparation, like antenatal classes but for your emotional health, and haven't been able to get it out there. You know, we've got the course out there ready to run. So, Mental Health Care Plans cover 10 individual sessions a year and 10 group sessions a year. We have, the groups we can usually get good numbers and um, yeah if they call up they realise that there's free childcare and things like that. But it's the groups that when they're pregnant it's hard to get numbers for them because pregnant parents don't think they're going to have any difficulties.

Psychologists Henshaw, Sabourin and Warning's (2013) study of help-seeking behaviour for perinatal women explored the preferences, patterns and barriers women face when accessing perinatal mental health care. Their findings suggest that women were reluctant to seek support from professionals and may benefit from increased education about the symptoms of and treatment options for perinatal mental illness. Sophie's experience and Lucinda's description of barriers to support reflects that of the participants in Henshaw et al.'s (2013) study, who identified poor knowledge about the nature of mental illness and opportunities for treatment and support. This finding is reinforced by Dana's story—her previous experience of help seeking for anxiety meant that she possessed knowledge of her own mental health and how to get support:

Dana: Because I'd been through it before I think. Had I not ... if it had been something that hadn't happened before I would have been, I don't know if I would have been so at ease going and finding someone, I wouldn't have really known where to find the help.

Zalia: So, maybe you knew what you needed to do because you had done that before?

Dana: Yeah, because previously, before having kids, in my twenties I had seen a therapist. And then I got to here and I was like, I know myself, I know what I need to do. And that's what you often read, it's always someone else that tells you, whereas me, I think I can tell the signs in myself.

For Louise, it was her mother's own history of postnatal anxiety that helped her access support:

Louise: So, I ended up going and seeing someone, because my mother had had [anxiety] with me and she knew. I wanted to try the natural way first so I got really heavy into exercise, I would exercise every day and just trying to get those endorphins going and stuff. And then I went and saw a psychologist down in Caloundra and I thought she was really good, and then not so much. And I tried those um, rescue remedy and that did help for a little bit. I don't know, because I've never had it but my mum's always said to me that if you get it we have to nip it in the bud. So, because she had always said that to me I think I identified with that and I knew what I had so I was more open with it. If I didn't have that information I would be thinking 'What's going on with me?'

Zalia: It sounds like, for you, that knowing about it [perinatal anxiety] has helped?

Louise: Oh, yes! It definitely has.

Psychologist Lucinda also raised concern about women's awareness of available support and health professionals' ability to recognise and respond to anxiety:

A lot of the mums will say they've been to their post-baby appointment and it hasn't been picked up and they could be sitting there crying and saying they're not coping. And that's really disturbing because they're not aware that they can receive that support and assistance. Some of them will say that they get to do their Edinburgh [EPDS] antenatally and they're feeling like that's not picked up either.

Lucinda's perspective aligned with Courtney's experience:

Oh, yeah I did it [EPDS]. I must have scored well or high because I remember them being like 'Tick, tick, tick, okay all good' which is funny because I was crying at that same appointment. No one has ever asked me 'How are you going?' Am I anxious? They've never asked that question directly, they've never touched on it. They just sort of, every appointment it feels like they just check your blood pressure, feel the baby, check that the heartbeat is there ... that's all they do. Sometimes it's like no one is really listening, or like we're on a different page. I feel like I'm asking and why aren't you picking up on these signs? It might be my persona, maybe they think I'm pretty cool and relaxed so maybe they're not really picking up on the problem that I'm communicating.
(Courtney)

They just dismiss it. I think I didn't appear desperate enough I'd say. I'm definitely very internal with it. (Carmel)

I would have thought I presented as pretty anxious. I felt like I wanted them to know, I felt like I wanted them to ask. And if they had asked I would have said something but I didn't want to bring it up. It felt like a burden. It's not like, 'Oh I've got a cut arm, I've got a sore back, or my stomach doesn't feel great'. To bring up the mental side of it, I found daunting. (Dana)

I remember one doctor saying ‘Well you're still coping’ and I was like ‘I have to cope. I have two children. I can't just stay in bed all day. I have to get up’. I wasn't coping. I was surviving. If I had been given the option I would just sit in bed all day and cry, but I can't do that because I have a family to look after. I don't have a choice in not coping. (Louise)

These stories all suggest a disconnect between the women's experiences of perinatal anxiety and the diagnosis and therapeutic input they received. These experiences led me to question the psychological literacy and knowledge held by health professionals to identify perinatal anxiety and appropriately respond to mothers' mental health concerns. Obstetrician Brenda described the barriers to offering support to the pregnant women who visit her clinic:

I actually had a patient that came to me, in the gyne clinic, and she said ‘You asked me a question last time and I told my friends about it and they asked what'd she ask you that for?’ And I said ‘What did I ask you?’ And she said I asked her, ‘How are things at home?’ And she had never been asked that before, so why had I asked her? So, I think that's an indictment on everybody else that she's seen. I routinely ask, you know, ‘Who's at home with you?’, ‘How are things at home?’ But I don't think I'm in the majority. I think that [health professionals] are just too busy. In fact, I end up spending too much time on their social history. It does take up time. And I have been told off for spending too much time with a patient. I must say in antenatal clinic I don't have time to ask those questions it's more ‘How are you?’, ‘Is baby moving’, ‘How are things going?’, and hopefully that will bring an answer, but I don't have the time in antenatal clinic to explore that more adequately, which is difficult. It's just the workload.

Midwife Maria also described barriers to providing support:

Fortunately, all public hospitals now have a home outreach service, or a home maternity service, where we visit them at home. Daily if necessary, second daily when we see they need a little more support. To weigh the baby, check on their breasts, check on their wounds if they have any whether that's an episiotomy or stitches that they have from a tear. This service was not around 10 years ago. It is enormously beneficial. We can see them generally up to 10 days [post-birth] and then if they fall into the category of meeting child health criteria then they get a Family Care Referral. But there's a lot of middle-class women who don't get into that category and don't qualify so if they don't recognise that they need extra help, or they do but then they can't get it unless they pay for it somewhere. They can see a lactation consultant but they have to pay for it.

Brenda and Maria's comments indicate that health professionals can face similar barriers to offering help to those the women come up against. The limited knowledge and practical constraints that Henshaw et al. (2013) found to be barriers for women accessing help are also influencing the type of care practitioners provide.

7.3 Medication

Medication to treat perinatal anxiety was another theme I identified from analysing the data. Feminism and pharmacology have a conflicting history, with critics of antidepressant use for women arguing that medicating women is socially motivated and oppressive (Griggers, 1997). Radical feminists have taken issue with psychiatry and medication, contending that psychiatry is oppressive in nature and fails to acknowledge mental illness as women's response to gendered subordination (Blum & Stracuzzi, 2004). Others have recognised women's mental illness as a type of rebellion in that it challenges the dominant ideology of motherhood (Taylor, 1995). For feminists who

consider perinatal mental health as having the potential for empowerment, rather than total oppression, the view can be taken that ‘the postpartum support movement is involved in the social reconstruction of gender and the female self’ (Taylor, 1995, p. 42). As the following experiences reveal, some of the women spoke of the positive role medication played in their recovery from perinatal anxiety. However, others described strong stigma and fear surrounding the use of medications for mental illness.

7.3.1 Stigma and fear. The women identified feelings of secrecy and shame for using medication to treat their perinatal anxiety:

It wasn’t until 12 months later that I talked about it and told people I went on medication, um, because I don’t think anymore that it’s something to be ashamed of, but I was very ashamed of it then. Mum doesn’t think I’m bad for taking it but she wouldn’t take it herself. And to start with, with the first baby it was a secret, no one knew. I didn’t tell anyone apart from Mum, I don’t think my sister even knew I’d been on medication. I breastfed my baby still and she’s how many months now and she’s fine. No one would ever have known. (Sophie)

I think the stigma around medication, people still have it. I don’t know why. I take medication for my back, I have no problem with that, with telling people I have a bad back and that’s fine. It’s still, even though it’s getting out there, it’s still ... and I don’t know why. Everyone around me is very supportive of it. If I told my parents they’d be like ‘Absolutely, whatever you need’, everyone I know ... yet ... I’d been going to the doctor on and off for other stuff, and it took me years to say something about medication to the doctor, even though I was seeing a psychologist, and even though I was like ‘I’m doing all this stuff!’ I just didn’t understand how bad I had gotten. (Dana)

The women identified fear as a barrier to taking medication for their anxiety, particularly during pregnancy:

I was worried about the effects, I don't know, I was worried that it would mess with her brain chemistry. That maybe she would be different, as she grew up she might show signs of anxiety because of it. But I was told that anxiety during pregnancy wasn't very good either. I had a few people talk to me about it and they all said the same thing really; that there aren't that many studies on it really so they don't know the effects but anxiety increases cortisol levels that that's not good for the baby either so. You can choose either way. So, maybe you choose depending on the need so if you're really not coping maybe it's better to choose the medication. (Tanya)

I only stayed on the medication for three or four months. I was very wary taking it whilst breastfeeding you know, I was trying to have a balance between me feeling better and not giving too much to my baby. The obstetrician was the one that prescribed the medication for me. He spoke to some psychologist and he gave me a few journal articles to say that it's okay and that made me feel better. (Sophie)

A friend of mine has a long history of depression and anxiety, ended up going off her medication when she was pregnant with her first. She was in a really bad way. And I said 'You need to go to the doctor, you need to go and get back on your medication' and she was like, even someone who has been on medication and knows what it can do for her, wouldn't. I think pregnancy is scary, they wanted me to go on medication when I was pregnant with David and I didn't. I wish now that I had. It was a fear about the effect on the baby more than anything else. I got into a GP and she was amazing. I walked in and she said

‘What can I do for you’ and I started crying and I was like ‘This is my current state and I never thought I’d have to go on medication, I’ve always resisted. But now is the time’. (Dana)

Despite previously having taken medication for anxiety, and with good results, Louise was reluctant to resume medication:

Louise: So, I decided to go to my GP and I said ‘Look, I need to go back on medication. I know I do’. I didn’t want to, but yeah, it’s given me back my life again.

Zalia: What were the GPs like when you were going on medication, did you feel supported in doing that?

Louise: Yes, yes. Both times very, very helpful. They were both really great, it was positive both times. And seeing the psychologist too. Like, even though I didn’t really like the second one, they’ve both taught me things that I use to this day. I haven’t had a panic attack or anxiety attack since I’ve been on those tablets. They say at least a year I’ll have to be on them and that’s fine. If I have to be on longer I don’t care. If I wasn’t on the medication I don’t know where I’d be right now. Probably in a mental ward.

Interestingly, Louise defended her use of medication by citing the interests of her children, a concept that connects to intensive mothering ideals:

It’s whatever works for you. If people say ‘Don’t go on medication’ I’m sorry, you’ve got to do what works for you. And when you have children to think about ... you ... they’re always going to come first.

The fear of, and reluctance to take, medication for anxiety reflects a significant decision-making dilemma for women that revolves around perceptions of risk (Van

Trigt et al., 1994, as cited in Stepanuk, 2013). Part of the difficulty in medication decision-making during pregnancy is the insufficient data available about the risks involved. Some studies have found risk factors for taking antidepressant medication, but others have reported on the risks of not taking medication when this course of action is warranted by psychological distress (Stepanuk, 2013). Interestingly, Stepanuk acknowledges that physicians who influence the treatment of mothers with mental illness have been found to hold misinformed views about the safety of medications, believe that pregnant women should be treated differently to non-pregnant women and held concerns about legal liability regarding treatment decisions. It is concerning that although health professionals provide advice on the risks of medication during pregnancy, many do not counsel women on the risks of not treating their mental illness (Stepanuk, 2013). As mental illness continues to be viewed as an indulgence, weakness or excuse, the stigma it carries remains significant (Kelly & Jorm, 2007). For mothers, this stigma is further complicated by motherhood ideology that characterises mothering and mental illness as incompatible experiences. With medication perceived as an indication of failure and not coping, mothers risk exposing themselves as ‘bad’ mothers should they need, ask for or accept medication to manage their anxiety.

Dana used her positive experience of medication to encourage others to consider it as a treatment option:

I’m such a big (medication) advocate now ... I find myself having this conversation with a lot of my friends. You know, you need to go and get on medication.

Dana’s determination to speak up about her experience of medication can be seen as a purposeful challenge to the ‘rules’ of motherhood ideology. It also raises

questions about women's use of medication as a potential radical act rather than an oppressive and silencing force.

Stepanuk's (2013) study of women's decision-making around perinatal mental health medication found that women's personal knowledge was the most significant factor in their decision regarding whether to take medication for anxiety or depression. This finding connects with the experience of obstetrician Brenda:

Brenda: Often, they come in, they're either on medication from their GP or they've stopped it. A lot of the time, I don't have any stats, but I'd say a third of the time they need to resume it [medication] during the pregnancy because they can't cope.

Zalia: Do obstetricians have much input regarding medication for mental health?

Brenda: Very little, I would have very little. The perinatal mental health team would be taking care of that, or the GP. If they've any history of depression or anxiety or anything we would offer them the referral. Generally, we don't see the women until about 20 weeks so before they've seen us they've actually had a midwife interview and so usually the referral has been done by the midwives at that time who do an EPDS screen.

Zalia: Do women seek your guidance for mental health medication advice?

Brenda: Yeah, yeah. Frequently they come in with a medication prescribed by their GP asking me if it's safe. I wonder why they even bother going to their GP if they don't even trust them. I have to explain that you know we have to balance up the risks to the baby against the benefits to you. Um, yeah that happens sometimes. But often times they come in on the medication their GP has prescribed them, they're still on it.

Zalia: What is your opinion on medication for perinatal mental health?

Brenda: They're generally well prescribed. It appears to me that they're just, that they're medicated as opposed to just getting counselling and I can cite an example from just last week. She wasn't pregnant but she wanted to get pregnant and she had anxiety and I asked if she had counselling and she said no, she wanted it but the GP just prescribed her Valium. And actually, that happens a lot with regards to depression, um, where people are just prescribed an antidepressant as opposed to just doing counselling or being referred to counselling.

Midwife Maria also spoke of medication's role in managing perinatal anxiety, and suggested reserving medication for more acute mental health episodes:

Particularly if they're in a neurotic phase, and if they have that severe lack of insight then you know it's psychosis. I mean, that's the difference between neurosis and psychosis. So yes, she has insight which means she's probably being a bit neurotic about things but we can get her awareness raised and educate her about those things and get it into perspective. But when she's gone into a place where she has no reasoning, she's got no insight. Then she's gone to another place, a place where midwives don't necessarily go. Then you need mental health intervention.

7.4 Conclusion

In this chapter, I have explored the 'Strengths and Support' findings. The women discussed a variety of formal and informal support networks that influenced their experience of perinatal anxiety. They described support from practitioners and emphasised the importance of care that was collaborative and holistic rather than solely focused on their mental health, and it was noted that practical support and reassurance

of mothering ability were particularly helpful. Doctors and psychologists were the first point of engagement for the women, but not all doctors or psychologists were considered helpful or understanding, and the women noted the importance of a strong therapeutic alliance and belief in their experience for them to be able to trust their practitioner. Of concern to me as a social worker was that only one of the women spoke about engaging with social work, and her experience was not positive. I identified an absence of social work presence in the women's experiences, which highlights a potential gap in the provision of holistic care for women. The absence of a social work presence is worrisome, particularly considering women's desire for holistic care that could approach their perinatal anxiety from within the complex context of their lives as mothers.

Women spoke of the support they received from family and friends as being instrumental in coping with perinatal anxiety. Friendships with other mothers were seen as especially important, and an opportunity for information and experience sharing, emotional connection and debriefing on the difficulties of motherhood. Mothers' groups also acted as a sounding board and a chance to normalise feelings of distress, struggle and difficulty. Residential sleep clinics were another substantial form of support for many of women, which implies the pressures of isolated mothering in a neoliberal environment. The holistic approach and practical support these clinics offered were considered vital for the women, who stated that they needed practical support before they could address their emotional wellbeing.

The women who spoke of their husband's or partner's support considered themselves lucky. The resilience of stereotypical gender norms was evident when women noted their thankfulness and pleasant surprise when their husband or partner provided practical or emotional support. 'Good' husbands were not seen as a given, and

women considered any positive input and support from the father of their child a somewhat unexpected perk.

Asking for help was a significant barrier to accessing both informal and formal support; stigma and fear were major barriers. The women expressed their fear of judgement and sense of failure when admitting that they needed outside help. Even asking for help from their husband or partner was a sign that they were not able to cope and were not thus ‘good’ mothers to their children.

Bound by intensive mothering discourse, the women struggled to prioritise self-care and hand over the care of their child to others. In a chicken-and-egg cycle, women experienced anxiety at the thought of separating from their children, yet longed for support and help.

Poor knowledge of available support was another notable barrier. The women were confused as to where they could find help for their perinatal anxiety and who would be responsible for helping them. Those who had prior experience accessing mental health support described the sense of empowerment that their knowledge of perinatal anxiety provided when they had when they needed help again. Practitioner knowledge of available support was also a concerning barrier, indicating that practitioners can face similar barriers to women in terms of recognising and responding to perinatal anxiety.

Medication was the final support the women identified. It was strongly associated with stigma and fear, indicating its use as a deviation from good mother norms. The women described their fear about the effects of medication use on their children, feelings of shame and secrecy, and worry about external and internal judgement for taking medication for a psychological condition. They either validated or explained medication as being necessary for their child’s best interests, or took

medication for as short a time as possible. The women were much less likely to accept medication during pregnancy because they feared how it would affect their growing infant, a theme consistent with the idea of the self-sacrificing good mother. As one of the women explained, taking medication can result in feelings of empowerment and could be considered a radical act that challenges dominant motherhood discourse.

The next chapter concludes my thesis by discussing the findings and proposing recommendations for future practice and policy in the area of perinatal anxiety.

Chapter 8: Concluding Recommendations

In this thesis, I have presented a feminist and qualitative exploration of the lived experiences of perinatal anxiety. Perinatal anxiety is a prevalent, yet poorly researched, area of mental health for pregnant and parenting women; it significantly affects women's wellbeing and the social, physical and emotional health of their infant. Dominant diagnostic custom means that perinatal anxiety is overlooked, with most research focusing on the experience of PND. Qualitative research that explores women's experiences of perinatal anxiety is largely absent in the literature. This research contributes to the academic discussion about perinatal mental health and provides valuable insight into the lived experience of women with this condition. I used in-depth interviews with nine women and four practitioners to explore experiences of perinatal anxiety. Drawing on these narratives, I engaged in a thematic analysis to illuminate the following three research questions:

- How do women describe their experience of perinatal anxiety?
- How is the experience of perinatal anxiety influenced by the broader social and political discourse of women's lives?
- What must be addressed to better support women who experience perinatal anxiety?

8.1 Critical Feminist Approach

I approached this research from a critical feminist perspective that sought to problematise women's lived experiences by connecting them to broader societal ideology and exposing issues of power, control and patriarchal oppression. This critical feminist framework encouraged deep knowledge creation that moved beyond women's everyday experiences to theorise the influence of institutions of motherhood and mental health discourse on perinatal anxiety; uncovering the 'gendered dimensions of stories'

(Fraser & MacDougall, 2016, p. 247). By applying a critical feminist approach to all stages of my research, I explored how power operates in the lives of women with perinatal anxiety.

My critical feminist approach to this study has implications for both the personal and public realms. While the knowledge presented here contributes to broader academic discussion that addresses perinatal anxiety at a public level, the act of conducting a critical feminist study potentially empowers at a personal/private level. By seeking out and valuing the expert voices of women themselves, I challenged what Dorothy Smith (1987, p. 34) refers to as the ‘difficulty grasping authority for women’s voices’. Listening to women’s voices is considered a radical act (hooks, 1989) that can challenge dominant ideology in which ‘women’s opinions are sharply separated from their lived experience’ (Smith, 1987, p. 35). By hearing the voices of women with perinatal anxiety, I acknowledged women’s everyday private lives as a source of expert knowledge; a direct challenge to the popular discourse of the public realm.

It is important to note that the voices I heard and presented here represent a partial telling of a complex story. As I acknowledged in previous chapters, the women in my study shed light on the experience of perinatal anxiety, but do so from within their social and cultural context. A critical feminist approach rejects the idea of a ‘universal woman’ (Fraser, 1997) whose experience represents all women. Rather, it is vital to recognise ‘the particularity of the position from which [women] speak, instead of claiming rights as absolute and given’ (Krolokke & Sorensen, 2005, p. 20).

8.2 Reflections on the Findings

For this research project, I set out to explore three key research questions that could yield insights into the experiences of perinatal anxiety.

8.2.1 How do women describe their experience of perinatal anxiety? The

experiences shared by the interviewed women provide insight into the complexity of perinatal anxiety as a mental health condition influenced by a broad range of biopsychosocial factors. The women shared feelings of significant external and internal pressure and expectation in their role as mothers, which initiated or fuelled perinatal anxiety and resulted in feelings of inadequacy and uncertainty. The women's stories spoke to the significant role that mothers' everyday lives play in the experience of perinatal anxiety. Birthing, feeding, sleep and the health and development of their infants placed the women under significant stress and were red flags for the presence of perinatal anxiety. These women's everyday lives were characterised by isolation, financial stress and changing relationships with family, friends and partners.

Mental health literacy was not easily articulated, with both the women and the practitioners struggling to recognise perinatal anxiety. The women expressed their rejection of PND as the label for their experience, and clearly noted that their experience of perinatal anxiety did not 'fit' the definitions of perinatal mental illness with which they were familiar. Fragmented mental health literacy meant that knowledge of available support was a barrier to receiving support. The women spoke of confusion as to where they could find help for their perinatal anxiety and who would be responsible for helping them in their situation. The practitioners' knowledge of available support was also fragmented, which potentially indicates that practitioners can face similar barriers to women in terms of recognising and responding to perinatal anxiety.

The women described a variety of formal and informal support networks that influenced their experience of perinatal anxiety. Both the women and practitioners argued the need for collaborative and holistic care that would address perinatal anxiety

within the unique context of mothering young children. Trusting relationships with practitioners were considered vital for women to ask for help when they needed it. Informal support such as friends, family and partners were considered central, and relationships with other mothers were particularly helpful in normalising motherhood and the experience of perinatal anxiety.

Residential sleep clinics were another substantial form of support for many of the women, with the holistic nature of support and practical help with mothering seen as a protective factor in the women's experience. In an underlying theme, asking for help was a significant barrier to accessing both informal and formal support because of the stigma and fear associated with being perceived as not coping.

Medication use for the treatment of perinatal anxiety was also strongly linked to stigma and fear. The women expressed fear about the effects of medication on their children, shame and secrecy and external and internal judgement for taking medication for a psychological condition. Those who decided to accept medication validated their decision as necessary for their child's best interests, and were less likely to take medication while pregnant.

8.2.2 How is the experience of perinatal anxiety influenced by the broader social and political discourse of women's lives? In this thesis, I used a critical feminist approach to problematise women's experiences of perinatal anxiety and connect those experiences to broader social and political discourse. I found that the dominant discourse of good motherhood and intensive mothering influences women's everyday lives, and thus their experiences of perinatal anxiety. I identified good motherhood ideology as present throughout all themes. Good motherhood discourse set the 'rules' of mothering for the women in my study, and represented an unachievable status that they nonetheless felt compelled to reach for. The women struggled to articulate what good

mothers were, but noted an intense drive to stick to the social script of the ‘good’ and ‘intensive’ mother: one who loved unequivocally, nurtured instinctively, coped effortlessly and selflessly devoted their lives to the needs of their child. When the women faced challenges in their role as mothers, felt dissatisfied or out of control and experienced perinatal anxiety, this was interpreted as a sign that they had let down ‘the motherhood’ and failed to achieve good mother status. Perinatal anxiety was experienced as incompatible with good motherhood, which I argue is a barrier to women identifying their struggles and seeking help and support. The women suffered guilt, self-doubt and confusion when they felt they may not have been coping well enough to meet the standards of good motherhood; these emotions are tightly bound to the experience of perinatal anxiety.

Social media was a conflicting influence on the women’s mothering. They identified spoke of social media that challenged dominant ideology as refreshing and liberating, as it offered counter narratives to good mother discourse. Conversely, social media was also disempowering in that it reinforced dominant ideology and left women feeling judged and filled with self-doubt.

8.2.3 What must be addressed to better support women who experience perinatal anxiety? I have drawn on the suggestions proposed by the women and the practitioners to inform my recommendations for the future support of women with perinatal anxiety. Encouraging a ground-up response to the question of what needs to change for women is important for research that sits within a critical feminist and mental health approach. Critical feminist research strives to create tangible change, rather than simply contemplate women’s experiences. Feminist theorists Marjorie DeVault and Glenda Gross (2012, p. 192) argue that ‘as feminist researchers, we need to use interviews to facilitate our participants’ and their communities’ understanding of the social world and

their efforts to change it'. By presenting the women's suggestions, I aim to build an understanding of what works, and what is needed, that is informed by mothers themselves.

Mental health approaches have shifted to recognising the importance of the consumer voice in the design, implementation and evaluation of services and support. This has been caused by a history of problematic mental health care outcomes when suggestions for practice have come solely from clinicians and researchers rather than consumers (Rose, Evans, Sweeney, & Wykes, 2011). Recovery-oriented mental health practice encourages respect for the uniqueness of individual consumers, the importance of consumer choice, attitudes and rights, dignity and respect, and including consumers in partnership, in communication and in evaluating support and services (Langer Ellison, Belanger, Niles, Evans, & Bauer, 2018).

When I considered what had to be addressed to better support women with perinatal anxiety, I noted three key themes from the experiences of the women and practitioners I interviewed.

8.2.3.1 *Someone to step in.*

I guess people who are around mums need to ask the question, because I don't think they go looking for it. (Dana)

During the interviews, the women and practitioners made suggestions for the future care of those experiencing perinatal anxiety. The women recalled struggling to recognise their anxiety when it was at its worst. As Simone noted, the women felt that it was family, friends and health professionals who could have assisted more by identifying the anxiety and supporting them to access help:

I couldn't see it, I just couldn't see it. Someone needed to say 'LISTEN! This is what you have to do'.

Dana raised the importance of practitioners asking women about their psychological wellbeing—she felt that anxiety was often missed by practitioners, and that opportunities for safe therapeutic relationships were subsequently lost:

I mean, maybe the child health nurses need to be ... are they really looking out for PND? Are they really looking out for anxiety in women? I've probably only had one (doctor) that's said to me 'This is really stressful for you, are you doing okay?' And just to have that ... and maybe that's why when I randomly saw her again she was the one that I was like, 'I'm losing my mind' I felt safe. I felt safe to say it, you know?

8.2.3.2 Building knowledge. Another key suggestion was education about the differences between anxiety and depression, and the need to recognise anxiety as a standalone mental health concern. This is a point that perinatal academics have raised in recent years (Field, 2018; Reck, Noe, Gerstenlauer, & Stehle, 2012), with Matthey and colleagues (2003) calling for perinatal anxiety to be acknowledged as separate from depression and referred to as PMD (postnatal mood disorder) instead of PND (postnatal depression). Matthey and colleagues (2003) argue that this expanded definition would work to recognise the broader scope of mental health issues that are experienced during the perinatal period. For Dana, this understanding of anxiety as a valid mental illness separate from depression would be helpful:

Separating the depression and the anxiety for new mums is a huge thing, because I think so many women would suffer from anxiety that they never would have had ... but they just sort of think that's okay.

Increased education for practitioners was also proposed for more effective perinatal mental health care:

I think that service delivery could be improved upon with information for midwives around holistic care. I think the extended (community) midwifery service looks at how you are mothering, it doesn't look at the mother as a person and how she is managing in her environment. There can be a whole lot of things happening that can impact on her caring or mothering but that's not something that the midwifery service can clinically help with. They might have an opinion, but that's not a trained opinion, it's an opinion. If there was a community-based social work service for example that actually went out rather than a midwife ... it's a different set of clinical skills. (Gina, social worker)

Gina's suggestion for a stronger social work presence in the mental health care of perinatal women aligns with the desire the women expressed for a holistic care approach. Social work played a very limited role in the experiences of the women in my study, with only one engaging with a social worker; this interaction had poor outcomes. This is surprising given the role and scope of social work practice. Social work theory and practice is based on a holistic approach to people's experiences (Bland, 2014), and is well placed to provide care for women with perinatal anxiety whose everyday lives are complicated by their biopsychosocial positioning.

As Tanya explained, practitioners' knowledge can significantly alter the trajectory of women's care for perinatal anxiety:

I think a lot of women may see a doctor who doesn't really know anything about [perinatal anxiety] or doesn't believe that it exists and so they go off thinking that it's just them, that there's nothing to do about it. Maybe some education, lots of education would be great.

8.2.3.3 *Safe spaces.* The option for holistic support within a residential setting was suggested as a much-needed resource for women with perinatal anxiety:

If you have an anxious mum, she probably needs to get away, and to have the security and safe place [residential centre]. It needs a holistic approach. (Gina, social worker)

I needed time out. I needed someone to take my baby away, safely, to just let me sleep. To know I could have gone there [residential centre]. To have a health plan or something with five free sessions so you have those there if you need them. I know it doesn't work that way but to be able to get on the phone and say 'Look I really need help today, can I come in and just sleep? Chat to somebody?' Even in a group session where there are people [professionals] there who are aware of those symptoms, those red flags, and can go 'Okay, this person has real issues and this is what we need to do'. (Simone)

Research has found that mother–baby units provide a positive environment for intervention that leads to successful outcomes for women with mental illness (Connellan, 2017; Gillham & Wittkowski, 2015). Unfortunately, the Sunshine Coast region has no residential mother–baby unit or sleep centre for women to access.

Although some of the women in my study had attended residential centres such as the Ellen Barron Family Centre and the Brisbane Nurture Centre, neither are designated mental health services. The Ellen Barron Family Centre is a residential child health service that addresses responsive settling and feeding, child development and behaviour, and general parenting skills and confidence (Children's Health Queensland Hospital and Health Service, 2017). The Brisbane Nurture Centre is a private mother–baby unit, and the only one of its kind in Queensland. The centre supports parents with sleep and settling skills, nutrition, baby massage, attachment parenting, adjustment to

parenting and feeding issues (Brisbane Nurture Centre, 2017). It also offers psychologist or psychiatrist review for women during their stay. Both centres are in Brisbane, which is over an hour's travel from the Sunshine Coast, presenting obvious barriers for Sunshine Coast women to access support.

8.3 Recommendations

Based on the above suggestions, I propose the following four recommendations:

- *Screening processes, education and therapeutic intervention should expand to include a woman's informal support network.* The women in my study spoke of needing someone to 'step in' during their acute experience of anxiety. Their experiences highlight the potential for changes to the way perinatal mental health treatment is delivered. I propose that a holistic approach to perinatal mental health treatment may be beneficial. As the women identified, informal support networks such as partners, family and friends can be a source of significant support and could play a key role in identifying perinatal anxiety and 'stepping in' to seek out help.
- *Anxiety-specific education to improve mental health literacy is needed.* Education for women and practitioners was raised as a suggestion for future practice. The women spoke of the need to identify anxiety as a standalone mental illness and increase women's knowledge of symptoms and treatment options. It was also put forward that health practitioners needed education on the warning signs for perinatal anxiety and the options for early intervention and treatment.
- *Increasing women's access to safe spaces for support and recovery is a priority.* The women and practitioners in my study saw mother-baby units, or residential centres, as a source of holistic and multidisciplinary support. Their regional

location acted as a barrier to accessing such support, exposing a significant gap in the care provision of mothers with mental illness. Further research into the geographical context of perinatal mental health care may help develop an understanding of the unique support needs of women who reside outside of Australia's metropolitan areas.

- *Hearing the stories of minority women is needed to build greater understanding.*

As I have acknowledged, my research presents the experiences of a group of women who represent the Sunshine Coast region's mainly white, middle-class, educated population. I recommend further qualitative research into the experiences of minority women whose ethnicity, cultural background, sexuality and socio-economic positioning will arguably influence their perinatal anxiety journey.

8.4 Significance of the Study

This study is significant because it brings the lived experiences of women into the discussion about perinatal anxiety, and connects these experiences to broader societal and political discourse. This research contributes to the academic conversation about mothers' mental health and works to raise the profile of perinatal anxiety as a standalone condition. By relying on the voices of women themselves as the source of expert knowledge, I have uncovered insights that are absent from the literature.

My research explored the everyday lives of women to illuminate the complex context within which women with perinatal anxiety mother. The study resulted in rich and meaningful descriptions of the lived experience of perinatal anxiety that I linked to the gendered nature of women's lives. The findings consider perinatal anxiety from a new perspective and offer suggestions for future practice and policy that recognise the multi-layered nature of perinatal mental health.

8.5 Conclusion

In conclusion, I have argued for the importance of a critical feminist approach to understanding the lived experiences of perinatal anxiety. With dominant diagnostic custom so focused on perinatal depression, perinatal anxiety continues to affect mothers' lives behind closed doors and in relative silence. This research has opened that door by seeking out and acknowledging the marginalised voices of women whose experiences of perinatal anxiety deserve to be heard. Research to date has not given space to these voices, which means that perinatal mental health continues to be viewed in isolation from the complex, gendered and tightly regulated institution within which women with perinatal anxiety mother. This research has challenged this dominant approach to perinatal mental health—but is only the beginning. Future research, policy and practice must begin with the experiences of women who are mothering through perinatal anxiety. Their expert voices must be heard, and valued, if meaningful change is to be achieved.

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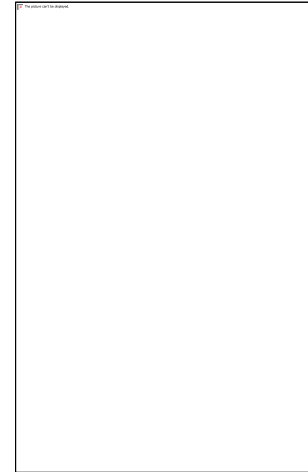
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Appendix 1: Initial Recruitment Flyer

Are you pregnant and experiencing anxiety?

- Excessive worry or fear that interferes with daily life?
- Intrusive or irrational thoughts that make it hard to concentrate, sleep or relax?
- Panic attacks?
- Feeling overwhelmed, a sense of dread, out of control or constantly on edge?



Would you like to share your experience by participating in my research?

The goal of this study is to learn more about anxiety for pregnant and parenting mothers by listening to the stories of women who are experiencing it. Very little research exists that values the opinions and perspectives of pregnant and parenting women. It is the goal of this research to use the experiences of women like yourself to begin much needed conversations about motherhood and anxiety.

Interested in knowing more about participating? I would love to hear from you!
Contact Zalia (Primary Investigator) via email: zalia.powell@my.jcu.edu.au

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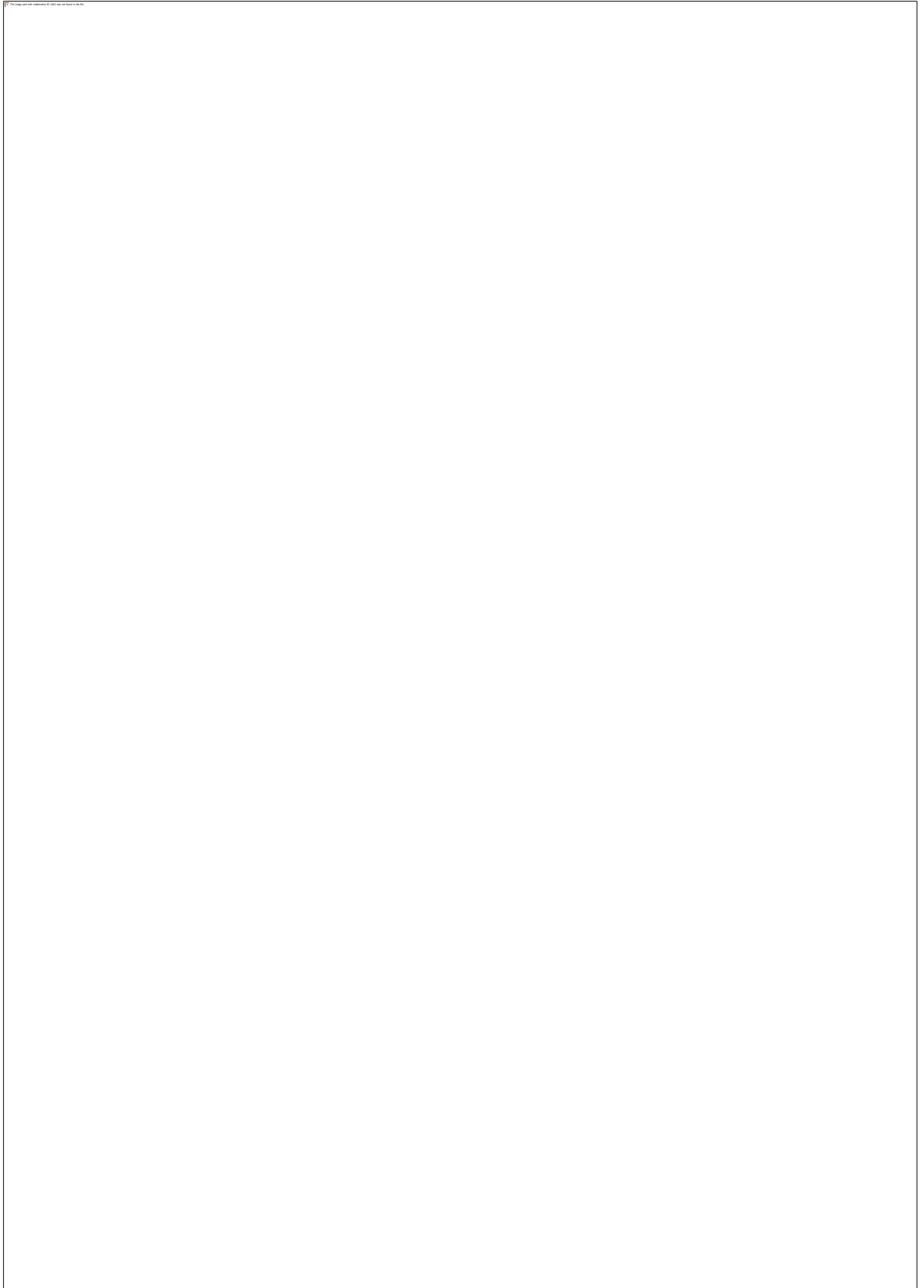
Zalia Powell

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Zalia Powell

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Appendix 2: Revised Recruitment Flyer



Appendix 3: Recruitment Flyer—Practitioners

Are you a perinatal health professional?

If you provide antenatal and/or postnatal care for women who are experiencing anxiety then I would love to speak with you!

I am seeking participants from multi-disciplinary health professions whose primary scope of practice is the perinatal care of women.

Participants will be invited to take part in a qualitative research project that explores perinatal anxiety through the experiences and perspectives of mothers and the health professionals who engage with them.

For further detail on participation in the study please contact: Zalia Powell (Primary Investigator) College of Arts, Society and Education, James Cook University E: zalia.powell@my.jcu.edu.au

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Appendix 4: Information Sheet

INFORMATION SHEET

PROJECT TITLE: **The Lived Experiences of Perinatal Anxiety**

You are invited to take part in a research project about the experience of women who identify as 'highly anxious' whilst pregnant and/or during the first year of motherhood. The study is being conducted by Zalia Powell and will contribute towards a PhD thesis for Doctor of Philosophy (Society and Culture) at James Cook University.

If you agree to be involved in the study, you will be invited to be interviewed on one or two occasions. The interview/s, with your consent, will be audio-taped, and should only take approximately 1 hour of your time. The interviews will be conducted at a time and venue of your choice.

Taking part in this study is completely voluntary and you can stop taking part in the study at any time without explanation or prejudice.

If you know of others that might be interested in participating, please pass on this information sheet to them so that they can contact me for further details.

Your responses and contact details will be strictly confidential. The data from the study will be used in research publications however you will not be identified in any way in these publications.

This study explores some sensitive and personal issues and experiences. Should you feel upset or distressed in any way, you can contact Lifeline's 24 hour crisis telephone line on **13 11 14** or access online information and support at www.lifeline.org.au or www.beyondblue.org.au

If you have any questions about the study, please contact

Principal Investigator:

Name: Zalia Powell

School: Arts and Social Sciences

James Cook University

Phone:

Email: zalia.powell@my.jcu.edu.au

Supervisor:

Name: Dr. Nonie Harris

School: Arts and Social Sciences

James Cook University

Phone:

Email: nonie.harris@jcu.edu.au

*If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office*

James Cook University, Townsville, Qld, 4811

*Phone: (07) 4781 5011 (ethics@jcu.edu.au) Cairns – Townsville – Brisbane –
Singapore CRICOS Provider Code 00117J*

Appendix 5: Informed Consent Form

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Appendix 6: Interview Guide

Interview Guide—Women

- Perhaps we could start by getting to know you and your family? In your own words could you describe yourself and your family? (Age, number of children, relationship status, ethnicity and socio-economic status)?
- Please tell me about your experience of being pregnant/a mother.
- How would you describe perinatal anxiety to someone who had not experienced it?
- Can you share with me your experience of anxiety?
- In your experience, what impact (if any) has perinatal anxiety had on yourself and your family?
- If you had a magic wand and could have altered that experience in any way, what would you have changed?
- Are there any thoughts or suggestions that you would like to discuss?

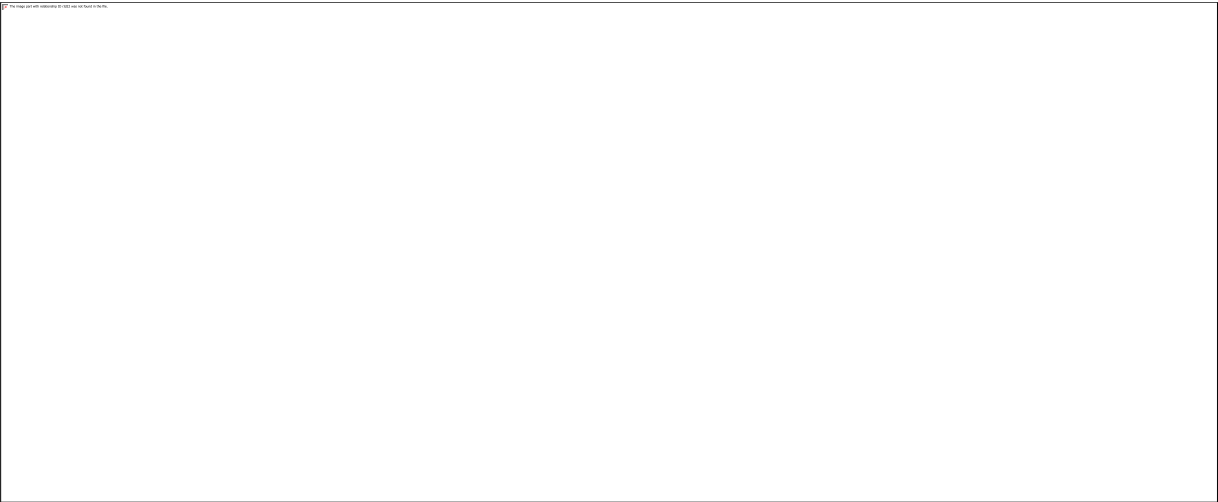
Interview Guide—Practitioners

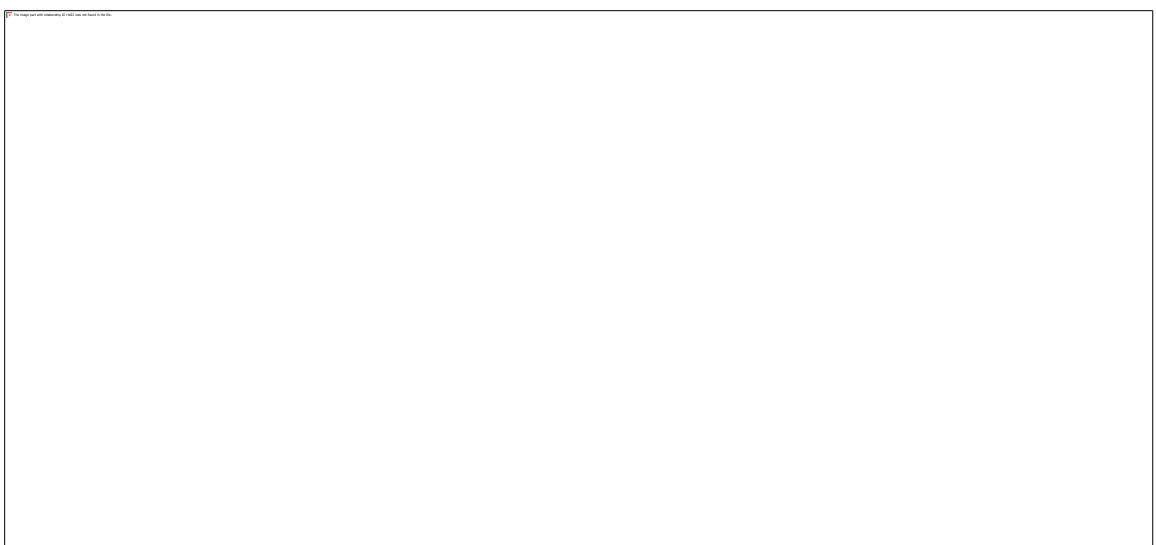
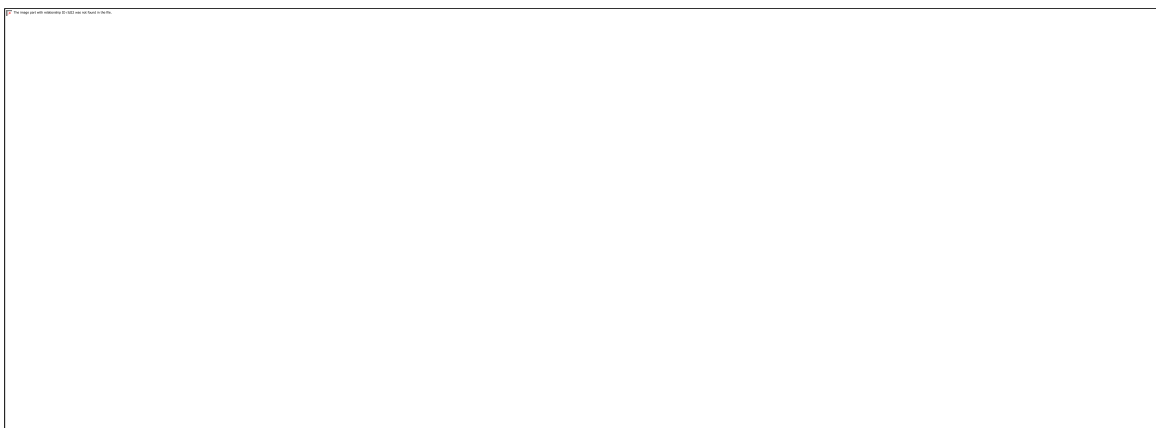
- Perhaps we could begin by gathering some information about you and your professional role? (Occupation/qualification, length of time in current field of practice, role in current field of practice, gender and country where qualification was obtained).
- Please tell me about your experience of perinatal anxiety as a practitioner.
- How would you describe perinatal anxiety?
- What are your thoughts and ideas about the impacts of perinatal anxiety?
- In your experience what have been barriers or strengths when working with women who have perinatal anxiety?
- Can you tell me about available supports and services for mothers with perinatal anxiety?
- Are there any other comments or thoughts you would like to discuss?

Appendix 7: Coding—Nodes



Appendix 8: NVivo Mind Maps





Appendix 9: Ethics Approval

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